PUBLIC HEALTH NURSING

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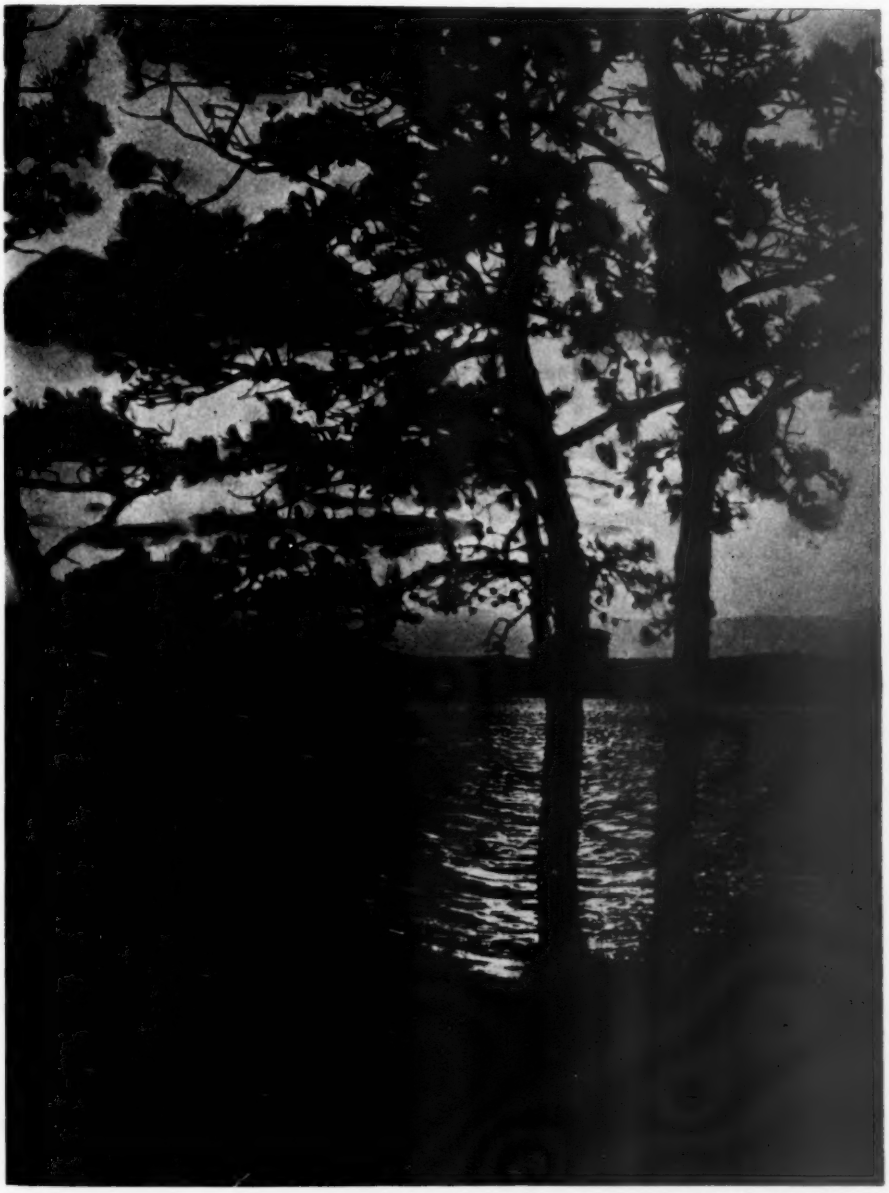

Photo by A. N. Thomson, Falmouth Heights, Massachusetts

Summer sunset through the pines, Cape Cod, Massachusetts

ATLAS GOES ON VACATION

ATLAS, THE TITAN, was supposed to have borne the pillars of heaven on his broad shoulders. Mythology does not state whether he was given four weeks' vacation out of each year of service as recommended by the N.O.P.H.N., but it seems quite likely that his posture would have been better and his general attitude toward life happier if he could have tossed his burden to another Titan for a few weeks every year and viewed the world as a free and unencumbered man.

Many public health nurses carry heavy responsibilities for 48 to 50 weeks of the year. The worries and troubles of hundreds of families are shared by us. The countless details of daily service in homes, schools, industries, and clinics crowd our days. Those with supervisory and administrative duties are dogged by anxieties of another sort—the demand for more nurses, the complexity of personnel problems, costs, the exacting effort to maintain effective community relationships. Many of us feel, if we do not look, like Atlas—bowed down by the weight of our particular duties and responsibilities.

Vacation comes as a precious opportunity to toss our burden to someone else and stop being Atlas; to get as far from work as is physically possible, so as to make the mental break more complete. For it is the mental burden that is hardest to cast aside. It is so easy to say, "Forget all about work," and so hard to discipline the mind to complete and speedy forgetfulness! But it can be done and it should be done, since only in that way does true refreshment come, and renewed vigor to attack the knotty problems. All of us have had the experience of seeing a mountain in some particular piece of work at the end of the week—and finding on Monday morning that it is only a molehill and easily surmounted. So on our return from vacation, all the mountains should have been flattened to molehills. And the burden of work should have grown light—even welcome—on our straightened shoulders. At least, that is the sort of vacation the National Organization wishes for you—our members and readers.

THE NURSE ATTENDANT

IT IS the responsibility of the public health nurse to teach someone to give nursing care in the home between her visits. Such care is frequently given by a nurse attendant, sometimes known as a "nursing aide" or a "subsidiary worker." These workers meet a very real need in homes where there is illness which does not require the continuous services of a graduate nurse, and where the duties include the general day-by-day care of the home and family.

Since the public health nurse is constantly called upon to teach and supervise the nursing care given by these women, she realizes the problems in regard to their preparation and the regulation of their duties in the home. Two articles have recently been published on this subject in PUBLIC HEALTH NURSING: "The 'Attendant Nurse' in the Home," by Lillie Young (March), and "Preparation of Nursing Aides for the Home," by Leora B. Stroup (April).

The three national nursing organizations—the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing—have a joint committee to study the whole problem of the subsidiary worker. A report of its subcommittee, giving suggestions regarding the supervision of these workers and their duties (page 398) is a welcome contribution to the setting of standards in this important field.

The Mental Health of the Family

By WILLIAM C. MENNINGER, M.D.

A well known psychiatrist discusses problems of mental health arising from a feeling of insecurity—which may be psychological, biological, economic, or social in origin

WHETHER OR NOT she wishes it, the public health nurse must concern herself with the mental health of the family. She deals with the family unit in almost all instances, rather than being concerned merely with the welfare of a particular patient. Her interest centers about service to the family in the home, whether her work is through the child in school, through child health conferences, through bedside care in the home, or through other types of contact.

The environment of her patient includes the physical setup of the home and the other members of the family. Thus, every public health nurse is familiar with situations in which the case problem in the home is expressed in terms of unhappiness, fears, worry, irritability, neglect. She sees failure of all kinds—economic, educational, emotional. For her to treat her patient usually means also to treat the environment—the family. Since this is true, it is her responsibility to evaluate those factors which contribute to family ill health, and to proceed effectively along paths which will better the environment in which the family is the major element, as well as to benefit the patient.

These facts lead one to the opinion that the public health nurse should have added experience and information about sociological relationships. As a basic part of this preparation she should have psychiatric training, dealing particularly with the mental health of the family and the personal relationships between members of the family. An even more essential need is that she know how to apply such information for the benefit of those homes in which she serves. The physician in his hurried, infrequent contacts may not recognize certain problems. Certainly it is unlikely that he will have the opportunity to see them as clearly as does the nurse. Furthermore, it is probable that his interest will have been directed chiefly to the patient; whereas the nurse, through her longer and more frequent contacts, learns to know the entire family and its problems and the relationship between these problems and the patient's illness.

When one begins to discuss the mental health or ill health of the family it is difficult to steer between the Scylla of generality and the Charybdis of some very specialized type of family distress. Furthermore, family ill health, if we may call it such, usually revolves about the ill health of a particular member, the rest of the family reacting to this illness and reflecting like mirrors their own responses to the sick member. Consequently, in the final analysis it is necessary to study the individual. But a study of the structure of the personality and how it functions in health as well as under stress and strain is a complete course in psychiatry. One does a gross injustice to attempt to summarize it in a few pages.

This discussion will therefore be confined to a consideration of one of the most common causes of family ill health—the feeling of insecurity. By a feeling of insecurity we refer to that sense of anxiety and uncertainty, some-

times quite unconscious, on the part of an individual toward the outcome of a problem, a responsibility, an opportunity, a situation. With sufficient confidence or reassurance we may feel no insecurity. On the other hand, when we lack confidence or reassurance we may fail in varying degrees, and the failure expresses itself in a limitless variety of manifestations. Most often these manifestations take the form of psychological symptoms such as fear or anxiety, worry, irritability, jealousy, suspiciousness, depression, excitement, and variations of these. Not infrequently the failure expresses itself in the development of physical symptoms, even physical sickness. In this connection, we are reminded that more than fifty percent of all patients present physical complaints for which no organic pathology is established. The person may make strenuous compensatory efforts to overcome the difficulty and in such instances we see another type of symptom—overzealousness, overconscientiousness, overactivity, excessive efforts, or sometimes aggressiveness.

From the psychiatrist's point of view this sense of insecurity is an effort at adjustment—perhaps more literally a threat to the person, of maladjustment or failure. It makes slight difference, if any, whether the insecurity is real or threatened. For this discussion it is more important to keep in mind that when any member of the family develops this sense of insecurity and begins to manifest some evidence of maladjustment or failure, it reflects on all other members of the family. They, too, react to this threatened or real failure of one of their number with varying degrees of insecurity, and thus possibly with the formation of symptoms.

It may be helpful to attempt to further reorient the reader to the psychiatric point of view. Each of us lives primarily to accomplish certain aims, to satisfy certain wishes, to accomplish certain achievements. Our daily functions of seeing patients or making friends, of attending meetings or making speeches, constitute the major part of our lives. They represent our strivings, our wishes, and our hopes. The physical frame in which we live is important because it does serve as our house and our storehouse of energy. But we can certainly assume that it is subservient to these wishes and that it is used to fulfill their realization. Whenever any of our satisfactions or gratifications is threatened or thwarted we react, sometimes with compensatory efforts, sometimes with a sense of insecurity and a desire to escape. It is to be expected that this physical frame may reflect some of this reaction. Because in family life we find an interwoven fabric of common aims and objectives, a failure which affects one member is reflected in the others.

While the sense of insecurity is initially always a psychological phenomena, it may be related to every phase of the individual's life. Its origin is most frequently concerned with one phase of his existence. Frequently it spreads so that it affects the individual's function in all phases of his life, but the failure may remain most conspicuous in the original field. The most common origins of this sense of insecurity in the family are shown in psychological insecurity, biological insecurity, economic insecurity, and social insecurity.

PSYCHOLOGICAL INSECURITY

By psychological insecurity, I refer to defects in the make-up or the functioning of the individual's personality. Such insecurity arises because of internal threats or deficiencies rather than external threats or dangers. We find many instances in which the family's insecurity results because of the internal threats arising in one of its members. The attempt to meet these internal needs often leads an individual to attempt marriage as a solution. Although there

are many causes for marital maladjustment a very common basis is the contrast in the personalities of the husband and wife. One might assume that during courtship they would become aware of this contrast, but their internal needs make them blind to it. Unfortunately, not until after they are married do they find their differences, their lack of mutual interests, the effect of difference in race or religion or education. They may never be aware of the fact that their discord has arisen because the husband unconsciously married a girl to replace and substitute for his mother, or the wife married to find a substitute for her father. A brief case story will illustrate the ill health that can develop in the family because of the dissimilarity in the personalities of husband and wife with a consequent lack of common interests.

A woman of 37 consulted her physician because of a menstrual disorder. Nothing was found either in the history or on examination to explain the difficulty. It was learned, however, that the menstrual disorder was a very minor complaint in a major disorder involving the family. The patient had been married 14 years and had one son 12 years of age. Although she and her husband had been raised in the same town it was not until after they were married that she discovered their great difference in interests. In fact, she had come to the conclusion that they had nothing in common and this she believed to be the basis of her husband's apparent lack of interest in her and his probable interest in other women. She cited as examples of their difference in interests that she liked movies and he did not; she liked to travel and see the scenery and he only cared to fish; she liked to go to church and he did not; he liked to be with people and she did not; he belonged to several clubs and she belonged to none; she was fond of music and he was not; he liked to drink and she disapproved of it. All of these were undoubtedly superficial causes for their unhappiness and yet they contributed to the marital maladjustment, to the wife's periodic depressions, and to her menstrual disorder.

The public health nurse must frequently be aware of family ill health that results from the birth of unwanted children. Not only are the results of such a situation emphasized by marital discord but there is always the unfortunate tragedy of the development of insecurity in the child. Many times we learn of families in which an attempt to solve the marital disharmony is made by having a child.

The following patient was first seen by a social worker. The patient's problem also illustrates how differences in temperament and interests between husband and wife may be a partial cause of family ill health.

Mrs. Brown was first seen at age twenty-three at the time of her first pregnancy. Presumably the first medical help was sought because of the pregnancy, but the problem confronting the doctor, the social agency, and the public health nurse was far more complicated. Mrs. Brown had been raised in an unhappy home; had worked her way through high school as a maid, living in another home; and had married her husband after a very short acquaintance, forcing him to take her into his home. His interest in her was a passing fancy since his background had been entirely different and the pregnancy only resulted because she felt her husband was slipping away from her and that a child might hold him. The husband had responded by refusing to have anything to do with her after she became pregnant and as the case was carried along was determined to obtain a divorce from her.

As has been intimated, the greatest tragedy in such situations is the effect on the unwanted child. I could cite many, many cases seen in psychiatric practice of the child who was unwanted, and who was taken care of grudgingly and consequently without affection. Many of our patients seen in later life present the results of such a lack of affection in their fruitless strivings, even as adults, to obtain love, and frequently their total incapacity to give any love.

BIOLOGICAL INSECURITY

A second major field of striving for every individual is concerned with finding physical comfort and meeting his biological needs. The public health nurse sees in many of her cases the

response of the family to the physical ill health of one of its members. Sometimes this response is anxiety, fear, or panic. A keen nurse can observe that in some instances the family is too solicitous, a fact that we can often attribute to an unconscious hostility. They lean over backwards to keep from falling frontwards. In other instances she can observe the more frank expressions of hostility in the form of neglect, disinterest, lack of sympathy.

With regard to biological needs for food it is recognized that the internal demands to satisfy this need are perhaps as strong as any drive in the individual. It is certainly a common experience that the threatened or actual sense of insecurity about food forces man to greater extremes than any other urge. In everyday life, the psychiatrist can see psychological insecurity that is manifested in physical (conversion) symptoms related to the gastrointestinal tract. These can be understood when we recall that the infant, who received his bottle or nipple regularly from the affectionate hands of his mother, soon came to identify food and love as being synonymous. Such an unconscious equation throws much light on understanding gastrointestinal disorders in which eructations, gastric distress, biliousness, and heartburn may frequently have a symbolic significance of insecurity, or a threatened loss of love, of which the individual is entirely unaware.

Undoubtedly the most frequent cause of family mental ill health is concerned with the biological needs and demands of the sexual life of the individual. The family unit has evolved as the most satisfactory method of meeting this need. Consequently, any sexual incompatibility, whether it be frigidity or impotence, sterility, promiscuity, or indifference, gives rise invariably in varying degrees to family ill health. It is a fortunate corollary that sometimes insecurity arising from these difficulties may be alleviated by instruction. The difficulty in many instances may be very deeply interwoven in the individual's life. But on the other hand there are many instances in which the family unhappiness results only because of ignorance—ignorance of sexual techniques or powerful fears of conception or pain, which the public health nurse, with sufficient training and understanding, may often help to correct.

Again, a case history may best serve to illustrate this type of family insecurity:

> A farmer's wife, 33 years of age, had gone to several doctors complaining initially of rheumatic pains in her arm and leg and of acne eruptions, and later of some occipital pain and extreme weakness. Despite much medical treatment, she had made no gain. For seven years, her entire married life, she had been a semi-invalid. Physical examination failed to reveal any cause for all of her complaints.
>
> To understand the situation one had to know much more about the family health and particularly about her relations with her husband. She was an alert, intelligent woman who prior to her marriage had been a school teacher. Against parental wishes, she married her husband, her only beau, who was a well meaning but plodding, simple individual. She soon developed her symptoms as a method of escape from him and an unconscious alibi for her inability to adjust to him. It is possible that she could have accepted his plodding manner and his lack of social interest or grace. However, their sexual relations were not only unsatisfactory but actually unhappy. She had tried to assume an attitude of duty and submission, but actually had never succeeded in doing so. His clumsiness combined with ignorance provoked her illness, the direct result of insecurity in this field.

Biological insecurity may result because of extramarital affairs and perhaps occurs more often in families in which the sense of insecurity in one member leads him to be suspicious that his mate is unfaithful. Jealousy and suspicion are in themselves mental symptoms which, if directed toward a member of the family, jeopardize or even wreck the mental health of the family unit. Every public health nurse is familiar with situa-

tions in which the family health is threatened because of the wife's suspicions of her husband, or vice versa. She may react with paranoid outbursts or irrational behavior, or she may develop physical symptoms or use other methods to demand more of his attention.

And there are still other forms of biological insecurity which are concerned with the sexual relationships between the husband and wife. A problem in the mental health of the family is present in those situations in which either the husband or the wife wants a child and the other does not. Equally threatening is the tragedy of sterility of either party. Gratification in sexual relations may be entirely absent for the wife in instances where pregnancy is feared, another factor that very frequently results in mental ill health for both the afflicted individual and the family.

ECONOMIC INSECURITY

In addition to psychological and biological security, economic security is essential for the mental health of the family. The widespread prevalence of economic insecurity of the family unit is undoubtedly a major factor in the present general unrest in this country as well as in others. The public health nurse is perhaps most familiar with this factor as a cause of mental ill health in the family, since it is her function and privilege to enter the homes of many such families. The causes of economic failure in individual families are legion. It may be crop failure or a cyclone, a ne'er-do-well provider or a spendthrift wife, a national recession, or a bank failure.

But there are far more subtle causes that have led to its widespread existence. One observes many families in dire need, and the mental health of such families suffers in proportion to their need. On the other hand, there are many instances that have come to the attention of every public health nurse of families whose attitude is that the government or the state or the city owes them a living, that one of these should provide a job for them. The paternal aspect of the government has led them to assume that like a father it will care for its children, regardless of what the children do, even though they do nothing! Similarly, it is a common observation to find some families who feel insecure because they have too little money, and others who feel insecure even though they have considerable money. Some in contrast have adjusted and found a new security at a new economic level. There are situations in which the individual's economic insecurity results because of his poor judgment—the person who buys a radio when the family needs food, the family whose members spend as fast or even faster than they make money, those people who have plenty but who always fear they do not have enough.

In evaluating or enumerating causes, one can recognize that the economic situation does not make or break the individual, nor the family. The response depends upon its adjustment to economic shortage, and no doubt in many instances is determined by the part the family plays in bringing about this shortage. Curiously enough, even through the recent severe national depression, mental illness, at least as judged by the number of patients hospitalized, did not increase. Some investigations at that time revealed the fact that there was perhaps even less mental illness directly due to economic stringency than during prosperous times.

We may be sure, however, that for all of us the threatened or actual shortage of funds, the loss of a job, or the financial pressure of unexpected emergencies results in varying degrees of personal, and consequently family, insecurity. In such instances this may precipitate mental ill health. I mean to state that economic insecurity may cause disastrous results in the health of the individual and the family, but in the major-

ity of these instances we must look beyond the immediate economic failure and into the personality for the origins and purposes and causes of this failure.

An example illustrating the result of economic insecurity is shown in the following case:

The patient was a 47-year-old wholesale grocer who all his life had had to go against many odds to succeed, but had built up a successful and large business. He had neglected his social, religious, and recreational life. A doctor was called to see him because he was sleepless and had some vague physical complaints referable to his abdomen. Despite medication directed toward the symptoms he did not improve and within a few days began expressing ideas of self-depreciation, failure, and hopelessness.

One had to go into the background of the family situation to learn that he had a large note due at the bank. He might have been able to pay this except that a major part of his business dealt with creamery products and for the preceding month the dairymen had been on a strike. None of this was revealed at the time when the physician was first called. But the sense of insecurity and impending disaster resulted first in physical complaints which later blossomed into frank mental symptoms.

Perhaps one of the most common causes of economic insecurity as seen by the public health nurse is physical illness, particularly when it affects the wage earner. In every instance of serious illness, the drain on the average family for medical expenses may be a threat to the financial security. The attempted solution varies. Some families weather such storms through employment secured by other members. If the sickness can in any way be related to an industrial accident some individuals develop what is regarded as a "traumatic neurosis"; many of these resolve entirely with a cash settlement from an insurance company or employer. Perhaps the majority of public health nurses attend families who have come to rely on the state or the city for their medical services, but even in such cases the financial security of the family may be threatened and family ill health result.

SOCIAL SECURITY

Finally, one of the most essential needs in human life is social security. For most of us the necessity to have people care about us and be interested in us and think well of us—in short, to have a happy relationship with those about us—is one of the major determining factors of our behavior. When, for any of many, many reasons, either a single member or the family as a group receives a blow to its pride or its prestige or its self-confidence, its mental health suffers.

Social insecurity very frequently results from disturbances within the family, the development of attitudes between various members of the family which makes for the insecurity of one of the members. Thus, unintentionally and quite unconsciously, the wife may try to rival her husband in her interests. Or perhaps she may become unconsciously jealous—even sometimes consciously so—of his popularity or his success or his acclaim. More frequent, however, is the rivalry that occurs between siblings, a rivalry that almost always centers about capturing the love or approval of the parents. A case illustrating this insecurity because of competition with a sibling is the following:

This patient was a 25-year-old young woman who was brought to the hospital because she had fainted. There was no history of previous fainting attacks and in fact no history of any serious physical difficulty. Examinational findings were all negative. The history, however, did indicate a serious family maladjustment. Her father was a prominent professional man who was domineering and gave little attention to his family. Her mother was a neurotic, high-strung, restless woman who was greatly attached to the only other child, a girl two years younger than the patient. This younger child was regarded as a model of behavior and was much more attractive physically than the patient. The family as well as friends seemed to have given her most of their attention and love, to the neglect of the patient. As early as the fifteenth year the patient began to retaliate for this lack of love by irritability, perversity, and occasional outbursts of anger. The family retaliated by

giving her even less attention and affection, and the vicious cycle started which led to almost a complete isolation of the patient by the family for several years. The patient responded with destructiveness, and with provocative, aggressive, and frequently combative behavior. For example, she cursed and screamed at people whom she regarded as friends of the family. She broke windows and occasionally broke up furniture. She physically attacked her sister many times and made many other such irrational demands for attention. The immediate cause of her fainting was never determined, but her whole solution of life centered around the insecurity she felt because of her family's neglect of her and the excessive affection showered upon her younger sister.

Social insecurity in the family often arises as a result of competition with other families. One is familiar with the expression, "Trying to keep up with the Joneses." More acute are the instances in which some misfortune has befallen the family, so that the family itself is threatened with social ostracism or condemnation, perhaps because of the behavior of one of its members.

An 18-year-old college freshman was taken to the doctor with a severe mental illness, presumably brought about because of his excessive interest in psychology in high school. One can go back further, however, to see that his illness began when he was six, at which time his father had served a penitentiary sentence because of misappropriation of funds. He never understood clearly the facts about his father's difficulty, and in fact not until he was in his late teens did he know just where his father had been through that period of his childhood. The mother had attempted to remain loyal to the father, though against great odds including her own better judgment and the fact that she did not love him. On the father's return the family moved to another town, and then to another town, and then to still another town, attempting to lose the past by making frequent moves. Nevertheless, insecurity was felt by all members of the family and this boy's illness was only one of the results.

Perhaps the loss of a sense of social security is most vividly shown in children. Little brother Robert gets ill and receives considerable attention and special indulgence, whereupon his next older brother Edwin begins to complain of vague physical distress. And again, John comes home from school tearful and upset because although he was nominated for secretary of his class he received only three votes. Harry's sense of security is severely, even though momentarily, threatened when his gang assigns him to play pigtail because he can't catch the ball. Martha makes a scene in front of company when it comes time for her to go to bed because although she consciously may not recognize it, her sense of insecurity makes her demand the attention of her mother by this irrational method.

In short, all of us behave and speak and dress and conduct our lives in accordance with what we believe other people will approve. We do so because we crave, and in fact must have, this social security. The family no less than the individual requires it, and its lack invariably results in family mental ill health.

WHAT CAN THE NURSE DO?

Following the presentation of all these problems of family insecurity, one might rightfully ask what the public health nurse can do about them. It has been my chief purpose to outline these problems for the orientation of the nurse. The subject of treatment is too large to cover in this presentation. Nevertheless, certain generalities regarding the management of such problems may be stated briefly.

1. In evaluating and treating such problems, the nurse must not rely merely on her common sense; she must be able to exercise an informed judgment. In the majority of the instances cited, the initial chief complaint turned out to be of very minor importance. Because a patient states that she has tuberculosis or that her marital life is happy the nurse need not accept what she says as a fact and be guided by it. The nurse must learn not to accept surface symptoms as giving the whole situation. *All*

that the patient tells you may be camouflage. If the nurse is to be of help to the patient and family she must be able to secure significant information from every source available, to weigh it in the light of known facts and observations, and to come to conclusions quite apart from the beliefs or opinions of her informants.

2. The public health nurse's chief job is probably that of education—often in physical hygiene but more often in mental hygiene. She must be able to make suggestions in regard to alleviation of any type of insecurity. She must know when to recommend and how to help the family find new activities—social, recreational, religious, or educational. She may be called upon for suggestions regarding John's school work, sister's troubles with other girls, mother's fear of pregnancy, father's jobless state.

3. The nurse must know where she may get advice and seek it on every occasion when she could profit by it. She should consult frequently with her supervisor and the physician in charge of the particular patient. She must know what social agencies are available in her community for the help of her patient or members of his family—family case work agencies, relief agencies, employment bureaus, medical clinics, child guidance clinics, and others. She must be able to judge when the patient should be referred to these or to the family doctor, the psychiatrist, or the school physician.

4. The public health nurse needs a solid foundation in psychiatry. If a major portion of her job is restoring and maintaining the health of the family, she must have an understanding of the human personality and its deviations in health and disease. Only with such training is she capable of understanding and dealing with the interpersonal relations in family life.

CONCLUSION

It has been my purpose to call attention to certain forms of insecurity—psychological, biological, economic, and social, any of which may threaten the family health. Public health nursing offers a unique opportunity for the recognition and the treatment of such situations. It is a challenge to nurses that they train themselves in the understanding and usage of psychiatric principles for the individual, so that they may in turn deal with the problems of mental health as they arise in the family.

Presented before the N.O.P.H.N. General Session, Biennial Convention, Kansas City, Missouri, April 26, 1938.

Strategists of the City

By MARY SCHIEFFELIN BROWN

The responsibilities of a board member in a changing community are discussed by the chairman of the Nursing Committee of the Henry Street Visiting Nurse Service

THERE IS ABROAD today a general awareness of human needs which is leading to a rapid development and evolution of the machinery with which to meet those needs. It is appropriate for us as board members to look at ourselves and examine the equipment we need in order to play a constructive and not a parasitic part in the changing pattern of social welfare.

There was a time in the past when a board member's interest and responsibility began and ended with the organization he served. In the early days of social work this was natural and as it should be. Most of these organizations were started by a person, or group of people, who saw a need in some locality and had the vision and the energy to do something about it. Their whole concern was the proper administration of the institution they had created to meet that need.

But as time went on, and social work and organized philanthropy developed, this exclusive attitude lost its usefulness. The setup of social and health work became more complicated. At the time the Welfare Council was organized in New York City in 1925 there was no central source from which anybody could get information about the different fields of social welfare. In some fields agencies overlapped and duplicated their work; in others the needs were inadequately covered. It was at first very difficult to get the coöperation of many agencies because they were suspicious of each other! This jealousy, because that is what it was, was the logical result of the attitude I have mentioned; the boards were so wrapped up in their own organizations that they were skeptical about joining hands with any others and thus were losing sight of the well-being of the community as a whole.

A PERMANENT PROBLEM

During the past few years things have been happening which change the picture still further. As a result of the depression and the appalling human problems which it caused, the government recognized its greatly added responsibilities in the field of social welfare. Emergency measures were passed. Temporary machinery was set up to meet these problems. As the years have gone on, it has been realized that there is a permanent problem and not an emergency one. There will always be a certain fraction of the population who cannot earn their livelihood—whether from physical or mental disability, or because of the rapid developments and shifts in industry. Therefore, there will always be the problem of relief for what Commissioner William Hodson of the New York Department of Public Welfare called "the residuary legatees of maladjustments in the social system." So today we find government entering the field to an extent that was not dreamed of ten years ago.

Now what does all this mean to board members of private philanthropies and institutions? (By and large, board members are directly responsible for the

privately financed and administered organizations only. Official agencies are asking committees of interested laymen to work with them more and more but the function of these committees is advisory rather than administrative.)

The change which has come about through highly developed organization and increased government participation in relief means to board members that exclusive interest in one's own particular organization is wholly inadequate if a board is going to do a good job today. Every bit of conscientiousness, ability, and enthusiasm which has always marked good board members is as necessary as it ever was, but there are added requirements of knowledge and experience which are needed to meet today's needs.

QUALIFICATIONS OF BOARD MEMBERS

Let us look at a board and see what its equipment should be. This hypothetical board is composed of good members only, because boards are less and less tolerating members who are dead wood or whose names are on the list as "window dressing." Different people are on a board for different purposes. Some have specialized technical or financial knowledge through which they make their contribution; others have the ability and the willingness to raise money; and still others are simply good citizens who are ready to give time and effort to something they think is worth while. Obviously, every member of a board cannot qualify along *every* line. Yet from the joint action of all the members come the policies which guide the organization, and those policies are constructive only insofar as the individual members are qualified.

What, then, is the knowledge a board member should have? First and foremost, he should know his own organization. He should know that its finances are sound; that each dollar is stretched to its greatest capacity and is being spent in the right direction. He should know the personnel well enough to be sure that personnel practices are friendly as well as efficient. He should have complete confidence in the ability, integrity, and personality of the executive director.

Second, a board member should know his field. It may be family welfare, or public health, or care of the aged, or recreational and character-building work. Whatever it is, he must learn what is being done elsewhere in the field. This knowledge comes slowly, but inevitably. By virtue of his experience with his own organization, he will be asked to serve on committees in related fields, and when it is possible he should do so. Because only by knowing what experiments are being tried, what progress is being made, and what methods are outworn, can he be sure that his own organization is in the vanguard and not lagging behind by doing an increasingly routine job. The by-products of board membership are sometimes more wearing than the membership itself! But they are of immeasurable value in increasing one's understanding of the problems of one's own organization.

Third, a board member should keep in touch with the official agencies in his field, particularly now when governmental agencies are taking on so much more than they have ever done before. The official agencies can never wholly take the place of private agencies for by their very nature they must do things on a larger rather than a more intensive scale. But for the good of the community it is of the utmost importance that there be coöperation and joint planning between the two, so that there shall be neither wasteful duplication nor gaps in service.

There is a perfectly sound, practical reason for all this as well as the idealistic one of wishing to give the best possible service. In these days of increased taxes and reduced incomes, it is far harder to raise money for private philanthropies

than it used to be. People feel, with a certain amount of justification, that so much of their income is taken in taxes for the health and welfare projects of the government that they are reluctant and skeptical about supporting private agencies as well. Boards can succeed in winning support for their organizations only by proving to the public that they are necessary and effective parts of the community's welfare, and they cannot do this unless the board members are equipped with the knowledge I have outlined.

Fourth, a board member should serve as a liaison between the professionals in the field and the general public, and as such he has a wider responsibility than simply the administration of his organization. A professional who is a leader in his field today said recently, "The early days of social welfare were the days of the Titans. We had our Jane Addamses and our Lillian Walds, who not only founded and ran their own organizations but took the leadership in every movement to right the wrongs they found in the course of their work. Today we professionals are in a different position. Organizations have developed until professional requirements and administrative problems take most of our time. We are in the field and gather the facts, and when we find abuses or omissions which must be rectified we depend on our boards to stand with us and take the lead in fighting for better conditions." So today a good board member must be ready when the occasion arises to appear at hearings, to plead with public officials, and to play his part in the struggle for social justice.

Fifth, there is another thing that I think is largely the responsibility of board members and that is to see to it that the human element, which is the heart and *raison d'etre* of all philanthropic work, is not dimmed by organization. Of course, if the executive director is of the right calibre there is perhaps not much danger of this. But just the same, it is possible for those who are coping with administrative detail every day and all day to lose their perspective. Sometimes they can't see the woods for the trees. It is up to the board members to see that "organization" never clouds the true purpose, which is to serve with friendliness and with wisdom the individual human beings who make up the community.

In conclusion, there is one more quality which is essential to a good board member, and that is a goodly measure of faith. I know of course that we must scrupulously live within our budgets; that up to a certain point we must cut our coat to fit our cloth. But—there would never have been any human progress if people with vision had not gone beyond what looked possible. The pioneers in social welfare had the faith that literally moved mountains, the mountains of ignorance, public apathy, political corruption, and lack of support. They did not go forward by being cautious. When they saw something which must be done they did it. They made others see it too and thereby won support. We need that kind of faith today—a belief that if what we are doing is worth while and necessary, we can make it possible.

Lecture given in a series sponsored by the Welfare Council of New York City and the Junior League of the City of New York, October-November 1938. Reprinted with slight adaptations from the original, published in pamphlet form by the Committee on Information Services, Welfare Council of New York City, April 1939.

A Medical College Affiliates with a V.N.A.

By HARMINA STOKES, R.N.

A plan for giving medical students an orientation to public health nursing

A COOPERATIVE PLAN for the instruction of senior medical students in one of the city health centers was developed in 1937 by the Long Island College of Medicine in Brooklyn, New York, and the New York City Department of Health. The Visiting Nurse Association of Brooklyn was asked to coöperate, and it welcomed the opportunity to contribute a small share toward helping medical students become community health conscious. Since 1931 the association has shared with various schools of nursing a similar educational responsibility for their students, so the affiliation seemed a logical step to take as well as a challenge. Such a purpose and plan suggested the beginning of a new era in medical practice, and it was with something of the glowing enthusiasm of the pioneer that the association accepted this new teaching opportunity. Back of it all lay the vision of better understanding and closer coöperation between physicians and the Visiting Nurse Association for the benefit of the people of Brooklyn.

Only one misgiving arose that seemed to create a real problem. It was the traditional right of every patient to the privacy of his own home. Traditions have a way of clinging to us like bark on a tree and cannot be torn from us without a twinge of pain! True, women observers had accompanied nurses into the homes, but a man—never! The consent of the family must be asked in each case, and the doctor's consent must be secured whenever the patient of a private physician was to be visited. Types of patients must be carefully considered. Only maternity patients of the Long Island College of Medicine—patients, that is, who had become accustomed to the attention of medical students—were to be visited.

The plan consisted of two parts: group instruction and home observation. Every four weeks a new group of ten medical students met for an afternoon in the Visiting Nurse Association headquarters with the professor of preventive medicine and community health of the College and the director of the Visiting Nurse Association. The nursing director gave a brief history of the growth and development of the organization, and stressed the part it plays in community welfare. The physician discussed some angles of the work in relation to preventive and curative medicine. Various activities were introduced to add interest and variety to the program. The film, *Sickness Takes No Holiday,* was shown. The bag and its contents were displayed, and a brief demonstration of bag technique was given. The contents of the bag attracted an unusual amount of attention from those masculine tool-loving minds! The orthopedic supervisor and the mental hygiene consultant met the group in an informal discussion of their work. A trip through the building followed. The afternoon ended in a social half-hour of relaxation in which refreshments were served.

The second feature was the observation in the home. Each medical student reported at the Visiting Nurse Association office in the health center for a half-day of observation. This program continued until the end of the medical school year. After a careful selection of cases to be visited, on the basis already stated, the supervisor or staff nurse reviewed

the home situation with the student. The professor of preventive medicine asked the students to submit written reports of their contact with the association, and from these the students' reactions were gathered. Some of them are most interesting.

One reported that the nurse gets results because she "is willing to roll up her sleeves and show the mother what to do." This "strikes a responsive note in the mother and she is more likely to listen to advice from such a person than she is to someone who just comes into the home and tells her what to do."

Many students were impressed with the way the nurses managed to win the coöperation of patients in obtaining medical care. However, in the case of one antepartum patient who failed to coöperate in an emergency the student expressed the opinion that it was just that sort of thing that lay behind the statistics of maternal and infant mortality.

One student recorded his observation of the real difficulty a physician meets in attempting to diagnose the patient's disease at home without facilities for diagnosis.

Quotations from two of the students' papers show a better understanding of the visiting nurse service and a willingness to use it—results for which we had particularly hoped from our contact with the students.

> The part these nurses play in the program of prevention and community health is clearly seen, for in the case of sickness their care and coöperation with the physician reduces the seriousness of the disease and helps to prevent its spread.

And again:

> How fortunate are the physicians of Brooklyn! If I practice in Brooklyn I shall ever have reason to need the coöperation of the visiting nurse. I shall consider it a privilege to avail myself of the service.

The experience has been exceedingly worth while and stimulating to the staff nurses who have introduced these students to the homes. The nurses consider that the affiliation has greatly enriched their own experience.

The association as a whole feels a deep sense of responsibility for giving these young physicians-to-be a better understanding of the public health nurse's work and its value to their patients. It is hoped that wherever they go to establish their practice they will seek this service of their own volition and will know how to use it to the best advantage for the benefit of their patients.

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Nurse Coming!

By HEATH M. STREETER

A patient who used the visiting nurse service during a long convalescence tells how the nurses contribute to the rehabilitation of patients, as well as giving bedside care

NURSE COMING! Three years ago I heard that greeting for the first time. I had just returned from the hospital, faced with a long convalescence during the ankylosis of a grafted hip joint. I was in a quandary to know where I might obtain the services of a graduate nurse for a few hours each day for a moderate fee. Then the hospital suggested the community nursing service in my town.

WHAT IS A VISITING NURSE?

Previously I had not even known of the existence of such an organization. Now, uncomfortably incased in plaster, I briefly speculated—as the nurse trudged upstairs—what a visiting nurse might be like. Would she be different from the hospital nurses? How would she accomplish those things that had seemed to require the services of an intern and several student nurses, and the facilities of a hospital dressing room? Would she be a Hollywood version of the ministering angel of mercy, refreshingly lovely, but perhaps fulfilling the adage, "beautiful but dumb"? Or would she be a battle-scarred veteran, grimly and painfully efficient, with the attitude that "the patient is always wrong" and that in all decisions "the nurse knows best"?

As so frequently happens, my fearful expectations were happily unrealized. My nurse was neither old nor young, neither homely nor beautiful. Equipped with her nursing bag and an amazing ingenuity, unobtrusively efficient, experienced in the ways of public health nursing, sympathetic and understanding, she accomplished the painful and disagreeable tasks with a minimum of discomfort to me. With suggestions and encouragement she helped me to meet and to overcome those obstacles that are encountered in every long convalescence.

In that year I became acquainted with each of the three visiting nurses of my community. I learned to know a little about their work, their value to the district which they serve, and what they mean to those long-term patients whom they strive to rehabilitate mentally as well as physically. Their ability to cope with the situation at hand was surprising. But even more of a revelation was the discovery that these nurses consider bedside care—though necessary and important—to be only part of the job.

REHABILITATION OF THE PATIENT

Of what use, they contend, are the doctor's treatment and good nursing care if these benefits are to be counteracted by boredom and tediousness for the patient—which finally turn into morbidity and despair? Of what use to himself, his family, or his community is the man who, though physically cured, is left bewildered and out of step with his former life, incapacitated as a wage-earner in his chosen profession as a result of his illness?

"He probably is going to discuss occupational therapy," the reader may remark at this point. "A grand thing for institutions capable of supplying the

materials and a qualified teacher. But where would a busy visiting nurse find the time—let alone the money—for such an undertaking? And furthermore, since the patient is at home, why not let the parents or relatives see to it that he is kept occupied?"

The family are willing to do all they can for the patient's welfare. However, there are certain limitations on what they can do. The first few weeks of the illness and the knowledge that it will be indefinitely prolonged constitute as much of a shock to the family as to the patient, and both must go through a period of readjustment. Moreover, beyond the usual recourse to books, radio, and needlework for amusement, the family's imagination is apt to be limited by pity and consequently is no more fertile than the patient's. Also the patient, through fear of being thought overexacting, may attempt to keep his needs and suggestions to himself. Before the family can assume its share of the burden a certain amount of instruction is necessary.

When the patient is physically able to engage in mild activity, he is interested in some phase of occupational-therapy work. Usually he only requires some help in getting started in this work and then he can continue by himself. However, if his earning ability has been destroyed through physical disability, or if he wants to do some remunerative work during convalescence, the initial start of getting the patient interested is necessarily followed by a discussion of ways and means and a consideration of limitations of ability. Once a decision is reached the nurse acts as guide and counselor, letting the patient gain confidence through his own progress.

Time is conserved by substituting instruction and discussion in place of the usual chitchat indulged in by patient and nurse during the bedside care. The problem of lack of funds and equipment is solved by these nurses through a reciprocal trade agreement brought about through years of nursing service in the same community. Former patients are willing to aid others by lending equipment they no longer need. If the patient requires reading matter the nurse knows who in the town has an available supply of books. If the patient wishes to make a hooked rug the nurse knows where a rug frame may be borrowed, and if necessary, where instruction may be secured. The cost of materials such as yarn, silk, crochet, or knitting needles must be supplied by the patient. Since all of these articles may be purchased at the five-and-ten-cent store they are not necessarily expensive.

Interesting examples may be found of rehabilitation through the methods used by these nurses.

Miss Black, a stenographer, was enabled through the loan of a typewriter to make profitable use of her long convalescence by doing public stenographic work. As a result she lost neither wages, typing skill, nor self-esteem as the result of her illness.

LEARNING TO WALK

Mrs. Caldwell was confined to her bed for two years with syringomyelia. Her husband and son worked during the day and attended to the housework in the evening. Since they were unable to afford either a housekeeper or practical nurse it was not a situation where one might easily say, "Leave it to the family." The family, irrespective of their inclinations, lacked the opportunity. The atrophy of the arm muscles was so slight that the patient was able to regain the full use of her hands and fingers through the exercise furnished by the operation of a toy typewriter and by needlework of various kinds. Learning to walk was another story, however. She would attempt a few steps only if the nurse was there to guide and support her, but because of muscular weakness and lack of self-confidence she refused to trust herself alone on crutches. Consequently

little or no progress was made. The nurse remembered that another patient when learning to walk had used a tripod type of support constructed by a member of the family. The nurse borrowed it for Mrs. Caldwell. Unlike a crutch, the tripod would support her entire weight without the danger of tipping; and being easily pushed over the floor, it did not require the usual precarious balancing necessary while a crutch is lifted and advanced for the next step. Her self-confidence easily restored, Mrs. Caldwell taught herself to walk, and today, although she still must use a cane, she does the greater part of her own housework.

Through the practice of nursing as a profession these nurses enrich their lives not only with the knowledge of patients well cared for and healed, but with the rewards of lasting gratitude and pleasant friendships; the rewards of unselfish service.

Regional Placement Service

The report on minimum standards for regional placement services, made by the N.O.P.H.N. Advisory Committee on Vocational Counseling

In April 1939, the Board of Directors of the National Organization for Public Health Nursing authorized the appointment of a national Advisory Committee on Vocational Counseling to which was assigned the responsibility of:

1. A study of the vocational problems of public health nurses.
2. Promotion of vocational counseling service to public health nurses and their employers.
3. A study of standards for and promotion of regional placement services.
4. Approval and public listing of regional placement services meeting the standards set by the Advisory Committee on Vocational Counseling, for the use of public health nurses and their employers.

In concerning itself with a vocational counseling service to public health nurses, the N.O.P.H.N. has two objectives: the improvement of service to communities, and assistance to public health nurses in preparing themselves for the needs of the field.

Since the proper selection and placement of nurses are vital factors in raising standards of service, this committee has been authorized by the Board to approve for the use of the field those professional placement services which in their opinion are serving the community without regard to profit and upholding the standards recommended by the N.O.P.H.N. in all fields of public health nursing. Therefore, in approving a placement bureau or service for the use of public health nurses and their employers, the committee takes into consideration the following general factors:

1. The bureau must be under professional auspices.
2. The bureau must be in a position to serve an area of sufficient size to warrant recognition as a regional service.
3. The bureau must be willing and ready to work out plans of coöperation with already existing approved bureaus.
4. The bureau must be willing to work with the N.O.P.H.N. and its committee on vocational counseling on all major problems of service.
5. The bureau must have a qualified public health nurse as placement secretary in charge of public health nursing positions. The bureau must have an advisory committee of lay and

nurse members to assist this placement secretary with special problems.

These requirements of an *approved bureau* are defined still further:

It would be expected that the bureau would work out with other approved bureaus such matters as the area of service, division of fees, referrals, application forms, and publicity policies, referring unsettled problems to the Advisory Committee on Vocational Counseling; and that the bureau would at all times work with the N.O.P.H.N. toward raising the standards of public health nursing, following the minimum qualifications for appointment to positions outlined by the N.O.P.H.N. and developing better working situations locally with relation to personnel practices, salary scales, et cetera.

It would be required that the approved bureau render quarterly reports to this national committee—giving an analysis of the needs of the field, amount and location of service, types of placements, amount of support, and other significant facts.

The bureau would be expected to seek help from the N.O.P.H.N. on positions of a strategic nature, or on local situations of employment that are out of the ordinary.

The qualifications of the placement secretary in charge of public health nursing positions should be:

1. Personal qualifications: tact, friendliness, imagination, poise, ability to speak convincingly, attractive appearance, and good judgment
2. Minimum qualifications for appointment to supervisory positions as outlined by the N.O.P.H.N.
3. Experience in the supervisory field

Desirable qualifications should include experience in:

1. Administration
2. Some sort of vocational guidance and placement, or study in this field
3. Work with board members, committees, and employers
4. Work in more than one place or type of situation—rural and urban committees, public and private agencies.

The bureau should be a member of a local or national association concerned with vocational problems, and the secretary in charge of public health placements should be given opportunities to keep abreast with developments in the field, through visits to other vocational services, visits to prospective employers, attendance at conventions, and other contacts with the field.

While the tentative approval of a bureau may be given at the discretion of this committee, based on the reports from the bureau seeking approval, final approval would be given only after adequate study of the bureau by a representative of the committee and evidence of satisfactory service over a period of at least six months. Visits or reviews for continued approval would be made from time to time.

ALMA C. HAUPT, *Chairman*
Advisory Committee on Vocational Counseling

The Executive Committee of the N.O.P.H.N. Board of Directors approved these standards on April 25, 1939.

Selling Nutrition to the Employee

By MARTHA S. PITTMAN

The industrial nurse teaches nutrition through her contacts with the individual worker, through classes for employees, and sometimes through visits in the home

STUDIES OF industrial conditions have shown that a great deal of malnutrition exists in industry. There are various reasons for this situation. Industry often favors a city location, which frequently means crowded living conditions for employees, with all the attending evils. Industry has not always paid a comfortable living wage, and unless the worker has money to buy adequate food it is difficult to put into effect a satisfactory nutrition program; that is a good deal like attempting to build bricks without straw. The working hours have been long—too long in many cases. The working quarters have been crowded and inconvenient as well as dark and poorly ventilated. Often disease, as well as malnutrition, has resulted.

We are living in a machine age. Never has there been machinery with such a high degree of perfection. And yet none of these high-powered creations can approach the human machine in the quality of its mechanism. Nowhere else do we find such perfect coördination, such delicate adjustments, such adaptability to different tasks. But the man-made machinery receives the utmost care and attention, because it costs money. How much care does the human machine receive? The answer has been little or none, because it has been too cheap. The result has been lessened efficiency and too short a life for the industrial worker.

With the advent of the public health nurse into industry the situation has improved. Here is someone whose sole business it is to give to the human machine some of the attention and care that it needs if it is to be able to do its best work.

FATIGUE A FACTOR IN PRODUCTION

Undoubtedly fatigue is a big factor in the efficiency of workers in industry. Fatigue seems to be a means of self-defense that the body possesses, which protects it from complete destruction. Waste products accumulate in the body as fatigue develops, and the working capacity is correspondingly diminished. Many factors contribute to this condition of fatigue. The tremendous rate of speed that so often accompanies industrial activities is one of these factors. Then there is the monotony of the task. Imagine doing the same thing—perhaps sorting peas or putting the caps on tin cans or packing cookies—hour after hour, day after day. Moreover, there is the noise that may be actually deafening, and a temperature either too hot or too cold. These factors, together with poor lighting, high humidity, and too few rest periods, make fatigue a common evil. The proper assimilation of food is next to impossible under such conditions. However, factors causing fatigue in industry are being studied and gradually reduced or eliminated.

How can a nutrition program be introduced into industry? Undoubtedly it can be expected to come through public health nurses. They have contacts with the sick, and diet is certainly an important aid to recovery from illness.

These contacts may be the point of entry. Nutrition is a matter of education. In some way the worker must be made nutrition-conscious. There are different ways of doing this.

Selling nutrition to the industrial worker presupposes that industry itself is already sold to the idea that the good nutrition of its workers is fundamental to business success. It is assumed that in large measure those who direct our industries welcome the advent of the public health nurse, believing that she will help to build up the health of their employees and thus indirectly increase the efficiency of their business.

If the nurse is to sell nutrition successfully to anyone she must believe in the importance of nutrition. Nutrition is not just a set of rules which are given out and then forgotten. The nurse must follow those rules herself. In the old words, "You must practice what you preach." The nurse cannot expect to persuade anyone to take his quota of milk unless she drinks milk herself. And why should employees eat fruits and green vegetables when they see the nurse sit down to a noon-day lunch of meat and white bread and potatoes? Suppose she is a pretty healthy individual in spite of the fact that she has broken a good many of the nutrition rules? She probably would have an even better physique if she had kept them. She cannot assume, either, that these little details of her own diet are going to escape notice in her industrial world. They never do. Someone always finds her out.

ADAPT APPROACH TO THE GROUP

The method of approach in a nutrition program necessarily differs with different groups. The nationality of the workers must be considered. A foreign-born group and an American group will have different needs. The social and educational background of the workers is also important, and the economic status of the group must be considered. Sometimes it is wiser to begin working with individuals; again, group contacts may be preferable as an entering wedge. Many times a combination of methods is most effective. Perhaps the beginning emphasis will be the curative aspects of nutrition; in this case individual contacts will be used. If preventive aspects of nutrition are to be stressed, group contacts are sometimes more successful.

Adults are usually more fixed in their habits than children; they often dislike to make any change in their routine.

DEMONSTRATION IS EFFECTIVE

Sometimes a rather spectacular demonstration is successful in arousing the interest of employees in nutrition. For example, there is the work done by Holmes,* who gave codliver oil to one group of factory employees while a similar group, serving as controls, received none. Then the number of colds and their duration and severity were noted. He was pleased to find that benefits were apparent for those who received codliver oil as evidenced by less time off duty because of illness. Something of that kind often makes an appeal and creates interest to an amazing degree.

The mid-morning lunch of a bottle of milk with an accompanying short rest period for a malnourished group has been found to yield generous returns in increased production that far exceeds the cost of the lunch. Such results are sure to impress the employer. On the other hand, the results of a similar test with a well nourished group may be less striking. The nurse should take into consideration the group with which she is dealing.

A nutrition clinic or class may be an effective method of selling nutrition to a group. If they are ready to accept teaching, a good deal can be accom-

*Holmes, A. D., Pigott, M. G., Sawyer, W. A., and Comstock, L. "Vitamins Aid Reduction of Lost Time in Industry." *Journal of Industry and Engineering Chemistry*, September 1932.

plished in this way. Some of the fundamentals of nutrition can be presented through these group meetings. Exhibits and posters often have an appeal and may make an impression beyond that of mere words. Sometimes an effective approach is an emphasis on the economic return that good health may be expected to make, with a discussion of diet as a factor in reaching the health goal.

LEARNING THE HOME SITUATION

If funds permit and the need and interest are evident, much can be gained by extending the work beyond the individual employee into his home. A preliminary visit to the home gives an insight into living conditions that is helpful as a basis for giving intelligent advice. These visits make it possible to observe not only the dietary habits but the accommodations which the home offers for rest, recreation, and sanitation, and the possibilities for good ventilation. Also, the general atmosphere of the home—whether it is peaceful or otherwise—is significant.

CONSUMER EDUCATION

Sometimes help is needed in budgeting the family income so that it may purchase a more adequate diet. With wise expenditure, a limited income may often be stretched enough to provide a good diet, whereas with careless buying it will be inadequate. Instruction may be needed in the actual preparation of food. It is surprising how many women are poor cooks. Classes in food preparation may be a desirable way to supply this type of information, and such a program has the advantage of reaching a number of families at one time. The planning of the meals may be at fault, and assistance may be needed in the actual purchasing of food. Consumer education is often needed so that the housewife may be able to answer the riddle which the grocer presents with his wares. She needs to know when food is a bargain and when it is not. A good course in consumer education will give her needed information in this field. Frequently, too, special diets are required for some member of the family, and help with these will always be welcomed.

Child health conferences where the babies may be weighed and measured and the mothers advised regarding the diet of the infants provide a means of helping the next generation of industrial workers to get a good start. These conferences also accustom the family to turning to professional sources of information for help on diet.

EDUCATION THROUGH MEAL SERVICE

A splendid step in the right direction has been the establishment by industrial groups of food-service units for the special convenience of their employees. When these establishments are managed by competent dietitians they have excellent possibilities for providing at least one meal during the day which approaches adequacy. When the cost can be kept down to such a low level that the patronage is one hundred percent, these meals can contribute much to the general good health of the group. In planning the meals, due consideration must be given to age and sex as well as to the nature of the employment. For example, the meals for women employed in shops and offices will be of a different type and served under somewhat different conditions from those of the foundry worker. Only by giving due consideration to these factors can such a meal service be expected to accomplish the desired end.

These are some of the methods that can be used in selling nutrition to the industrial worker. The nurse's ingenuity will suggest others to her. If she, herself, believes in nutrition as a health factor, she will find it an effective tool in her public health program.

Presented before the Industrial Nursing Section Round Table, Biennial Convention, Kansas City, Missouri, April 27, 1938.

Working Together

By LOUISE BUNCE

A small community's coöperative plan for the treatment of crippled children, financed by a service club

PHYSICAL THERAPY was provided for the children of Middletown, Connecticut, two years ago for the first time, through the coöperative efforts of the hospital physical therapist, the District Nurse Association, a service club, and interested townspeople. Up till this time the city—a community of 26,000 population—had no physical-therapy service for its crippled children. These patients were kept under close supervision by the District Nurse Association, and were sent to their family physician or to the Newington Home for Crippled Children—an institution 15 miles away for the treatment and rehabilitation of orthopedic patients—for a periodic orthopedic examination. But they could not be taken to Newington for physical-therapy treatment two or three times a week because of transportation problems.

The physical therapist who did part-time work at the local hospital in the city offered her services to the District Nurse Association for a year, and a plan for the treatment of these patients got under way in May 1937. Because the budget allotted to the Association by the Community Chest allowed for no extra activities, the work was of necessity a volunteer service for the first year. In the beginning there were only three patients. But the number steadily increased until by the end of the year thirteen children were being treated. The problem of securing a place for the treatments was rather difficult. The hospital has no physical-therapy room; all treatments there are given at the patient's bedside or in the x-ray room, which is already overcrowded. The patients were therefore brought to the District Nurse Memorial House for treatment. And because at that time no room could be given over to the work, anything from the kitchen table to a nurse's desk was used for a treatment table. Before the year was over, however, a pleasant, sunny room in the House had been turned over to the physical therapist, and gradually simple equipment had been collected, most of it donated by interested townspeople.

By the end of the year the interest in the work had grown to such an extent that one of the local service clubs, the Middletown Exchange Club, came forward with an offer to finance the project. They arranged to pay the physical therapist for the two hours a day she spent with the children. Every minute of these two hours was utilized, with thirteen children each receiving from one to four treatments a week. A committee made up of representatives from the Exchange Club and the District Nurse Association board assumed charge of the project.

The patients have been referred by local physicians, by the Newington Home for Crippled Children, and by those in charge of the program for crippled children under the State Department of Health. Any interested agency may refer a crippled child, however. The children receive periodic examinations at the physicians' offices, at the Newington clinic, or at the state clinics. The doctors' suggestions and orders are

carried out by the physical therapist. Transportation of the patients is provided by volunteer workers in the community.

The physical therapist takes care of only those patients who are able to come to the building. The nursing care of bedridden orthopedic patients is given by the district nurses; as each patient is referred to the Association, the nurse on the case has a conference with the physical therapist, and a plan is made for giving necessary care at home. The nurses are constantly on the lookout for heretofore unrecognized orthopedic patients. These new patients are sent to physicians for examination, and many of them are eventually referred back for physical-therapy treatments.

The age limit of patients treated is sixteen years. Eighteen children have been treated to date. Five have been discharged from care. The types of cases so far treated include poliomyelitis, scoliosis, brachial paralysis, congenital deformities, spinal epiphysitis, fracture deformities, and birth injuries. Muscle tests are given to the poliomyelitis patients, and photographs are taken of the scoliosis and posture patients twice a year.

The end of the second year is in sight, and it is the hope of all those concerned with this part of the public health nursing program that the work may be carried on, with the expansion which will be necessary as an increasing number of patients are referred for care.

Nurse Placement Service

N·P·S CHICAGO paraphrases a well-known quotation by saying, "Now is the time for all good nurses to come to the aid of nursing." Interpreted, it means that at this season of the year nursing positions are pouring into the office for immediate, summer, or fall appointments and that nursing will go forward if enough available and ably equipped nurses can be discovered to fill these needs. It is a timely suggestion to nurses contemplating a change or seeking new opportunities. Nurses do not always realize the time element involved in the assembling of their professional biographies—the kind of records the service needs and the prospective employer expects from a professionally sponsored and conducted agency.

In the month of April, N.P.S. received 223 applications from nurses and 185 new positions for all fields it serves. It handled an increase of 33 percent of total open positions compared with April 1938, with the same percent of increase in total registrations of nurses. The new positions in April were in 22 states throughout the country. N.P.S. made 807 referrals of nurses to positions.

In public health nursing the largest demand is in the generalized field and the next largest is for school nurses for fall appointment. For upper-level positions and specialized positions there continue to be distinct shortages of qualified candidates to meet the discriminating requirements that employers stipulated. But nurses, too, have discriminations of various kinds—geographical location and climate, salary and type of organization. An announcement of public health nursing placements upon which release has been secured will probably be ready to be published in the next issue. Placements in all fields are the highest in four years.

We have been out "conventioning"

and speaking a great deal of late. N.P.S. set up a temporary office for interviews at the following meetings: National League of Nursing Education, New Orleans; Tri-State Hospital Assembly, Chicago; Michigan State Nurses Association, Kalamazoo, Michigan; and the Midwest Safety Conference, Chicago. Miss Tittman spoke at the League meeting and the Michigan state meeting, and also at the institute of the Northwest District of the Indiana State Nurses' Association in May. Elizabeth Mackenzie, who is in charge of N.P.S. public health nursing activities, recently spoke at Marquette University, Milwaukee, and interviewed public health nursing students.

ANNA L. TITTMAN
Executive Director

How Would You Answer This?

We are publishing excerpts from the letter of a Maine nurse in response to the questions raised by May Bailey, published in this column in the April issue. Further discussions of the important subject of sterilization of supplies for home delivery will appear in subsequent issues.

Send your suggestions and your problems to the Maternity Center Association, 654 Madison Avenue, New York, N. Y.

It is not necessary to have a pressure cooker for sterilization of supplies. The mother may be instructed how to use her oven. Nor is it necessary to stay with a patient during sterilization. If the patient cannot be taught to sterilize her supplies, it is doubtful whether she can be taught to keep materials sterile after the nurse has done the work.

Washing and airing may be sufficient, but the patient learns a great deal from the teaching of sterilization of supplies.

PAULINE B. LANDRY, R.N.
Biddeford Chapter, American Red Cross, Biddeford, Maine

Helen Schoenemann, Brooklyn, New York

Subsidiary Workers in Nursing Agencies

Suggested types of supervision of subsidiary workers placed through nursing agencies and a list of duties for such workers

THESE SUGGESTIONS in regard to the supervision and the duties of subsidiary workers have been prepared by a subcommittee of the Joint Committee to Outline Principles and Policies for the Control of Subsidiary Workers in the Care of the Sick, of the three national nursing organizations, with the assistance of a committee appointed by the American Home Economics Association. The material has been approved by the boards of the three national nursing organizations (American Nurses' Association, National League of Nursing Education, and National Organization for Public Health Nursing) for publication, with the understanding that the report is tentative and that criticisms and suggestions are invited.

The term *subsidiary workers* as used in this report includes all persons other than graduate, registered nurses, who are employed in the care of the sick, such as so-called practical nurses, attendants, nurses' aides, et cetera.

I. TYPES OF SUPERVISION

A plan for the supervision of subsidiary workers placed through nursing agencies should include:

A. Selection*

Workers should be selected in relation to the situations they are to meet and the services they will need to contribute for the relief of suffering and the restoration of normal conditions in the homes to which they are called. Some of the qualifications essential for the subsidiary worker are:

1. Good health (complete physical examination)
2. No serious physical handicap
3. Willingness and ability to do housework
4. Pleasing personality
5. Understanding of limitations but enough self-confidence to give family confidence in her
6. Attention to personal hygiene and neat, clean appearance
7. Sympathetic understanding of problems of the family
8. Sense of humor and ability to get along well with people but maintain dignity and avoid gossip

B. Placement

This is one of the most important of all the points in supervision. Things to be taken into consideration when placing a subsidiary worker are:

1. Type of situation
2. Preparation of worker to meet the situation
3. Personalities involved
4. Religious prejudices, if any
5. Racial prejudices, if any

C. Introduction to the field

When subsidiary workers are placed by nursing agencies, they should receive instruction as to policies of the agency and the procedures to be carried out by the worker. This can most effectively be given by an introductory period of from one week to ten days, including:

1. Lectures
2. Demonstrations

*Reprints of this report will be available. The committee is now giving attention to the problems of the preparation of these workers.

3. Discussion meetings
   a. Continued instruction by periodic group discussions of problems as they arise
   b. Discussion of individual cases with the supervisor upon her visit to the home
      The number of visits by the supervisor will depend upon the type of situation and the amount of guidance and help needed by the individual worker. A minimum of one visit for each place a worker is placed and additional visits as required for instruction in regard to new or special procedures is suggested.

D. Records
   1. Instruction in keeping records is given by the supervisor.
   2. The supervisor makes use of records for the purpose of supervision.

II. DUTIES

The following is a tentatively suggested list of duties for subsidiary workers in homes, where illness necessitates their employment:

A. Home management
   This may include assistance to the mother or housekeeper; direct charge of the home during illness in the absence of the mother; or teaching other members of the family—such as the daughter or son of suitable age, the husband, or a relative or friend—to assume at least partial responsibility for the care of the home.
   The worker's duties will depend on the situation in the home.* The duties may include:
   1. The care of well children, with special attention to their regular routine of rising, bathing, dressing, eating, playing, and attendance at school
      a. Cleanliness: Give baths or see that bathing is done if necessary
      b. Clothing: Dress the children or see that they are properly dressed according to the weather and their activities
      c. Activity: Direct the play of small children and the activities of older children as the situation demands
   2. The planning of meals and the buying, preparing, and serving of food according to the needs and income of the family
   3. The responsibility for the regular family routine including such household tasks as cleaning, ventilating, and keeping the house in order; airing and making beds; and washing dishes
   4. Such washing, ironing, and mending of clothes as time permits and is necessary to keep the family presentable

B. The care of well infants. This may include:
   1. Preparation of formulæ under the direction and supervision of a registered, professional nurse** according to the doctor's orders
   2. Preparation of other food such as cereals, vegetables, et cetera, according to the doctor's orders, and under the direction and supervision of a registered, professional nurse
   3. Bathing

*Unless there is a special understanding between the subsidiary worker, the family, and the supervisor, the worker should not be expected to do such work as spring or fall housecleaning; cleaning walls and windows; heavy laundry such as blankets and an unreasonable number of sheets or other heavy articles; making of garments; or doing the work in connection with parties for various members of the family.

**Any special treatment or care in connection with any complication or unusual condition associated with the routine procedures listed in this outline must be administered or carried on only upon the explicit order of the physician and under the careful supervision of the registered, professional nurse supervisor. For example, brushing the teeth of a patient with a sore mouth is more than just a routine cleansing procedure.

4. Following of the accepted routine of habit training for the infant; that is, regular hours of sleeping, eating, using toilet, et cetera

C. The care of mildly ill, chronic, convalescent, handicapped, or aged persons who do not require the expert care of a registered, professional nurse; or the care of more severely ill patients in intervals between the visits of a registered, professional nurse
The services include:

1. Making, airing, and changing the patient's bed
2. Changing the linen of the bed occupied by the patient when necessary to keep the patient clean and comfortable
3. Bathing*
   a. Washing the face and hands or assisting with same
   b. Cleaning the teeth or assisting with same
   c. Preparing the tub for a tub bath or shower and assisting the patient to take a tub bath or shower
   d. Caring for the patient's hair and nails (finger and toe)
   e. Changing the patient's night clothes
   f. Maintaining a daily routine for the comfort of the patient, including:
      (1) *Morning care*
      Give bedpan (cleansing afterward)
      Wash face and hands
      Brush teeth
      Give bath
      Give back rub
      Change bed linen if necessary
      Comb hair
      Care for nails
      Give fresh water
      Adjust window and shades
      Tidy room
      Prepare and serve breakfast (assist or feed as necessary)
      Brush out crumbs
      Give book, newspaper, glasses, et cetera, if desired
      Care for flowers

      (2) *Other care during day*
      Give bedpan (cleansing afterward)
      Give fresh water
      Prepare and serve lunch
      Adjust pillows, et cetera

      (3) *Evening care*
      Wash face, hands, and back
      Brush teeth
      Give back rub
      Prepare and serve supper
      Give fresh water

      (4) *Night care*
      Give bedpan (cleansing afterward)
      Give back rub
      Smooth sheets
      Adjust pillows
      Adjust windows and shades
      Give extra blanket (if necessary)
      Extinguish lights as indicated

      (5) *Changing position* (Moving and lifting of patient with acute illness, fracture, or other injury should be taught and demonstrated individually by the registered, professional nurse supervisor.)

      (6) *Food for the sick*** The diet will be prescribed by the physician.) This includes:
      Preparing food
      Serving attractively
      Using appropriate methods—drinking tube or straw, glass, spoon, or feeder
      Assisting patient

D. Responsibilities in relationship to physician. The worker:
1. Helps to maintain the patient's confidence in the physician.
2. Avoids any criticism of the physician.

*Special types of baths or treatments are given only under specific orders by the doctor for the individual patient and with demonstration, instruction, and supervision by the registered, professional nurse.

**Special diets are prescribed by the physician. The preparation should be taught by a nutritionist or registered, professional nurse. This is considered a special treatment and the same rule applies to all special treatments; that is, such a treatment must be ordered by the doctor, and the execution of it taught and supervised by the supervising nurse.

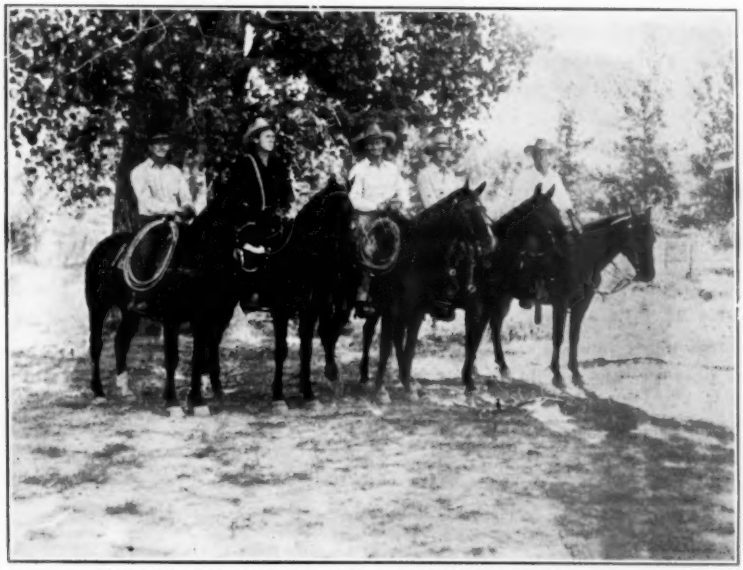
3. Reports signs of changes of the patient's condition to the physician.
4. Follows explicitly orders of the physician.

E. Responsibilities to the nurse supervisor.* The worker:

1. Reports all new orders of the physician to the nurse supervisor in order to provide for instruction, demonstration, and supervision.
2. Discusses problems of management of work with the nurse supervisor.
3. Reports to the nurse supervisor before leaving the case.
4. Keeps and turns over to the nursing agency such records and reports as are required by the agency and the physician.

*Since no special treatment may be given until provision for instructions, demonstration, and supervision has been made, the subsidiary worker must seek the advice of the nurse supervisor; if she is not available, the attendant must seek instruction from the physician.

This report is also published in *The American Journal of Nursing*, July 1939.



Courtesy of Bones Brothers Ranch and W. Thomas McGrath, photographer

JUST a-ridin', a-ridin',—
Desert ripplin' in the sun,
Mountains blue along the skyline—
I don't envy anyone
When I'm ridin'.

Badger Clark—*Ridin'.*

Gleanings

Suggestions in regard to improvised equipment, methods of publicity, and new ideas that have proved practical are published in this column. Contributions are welcome.

A RESOURCEFUL FATHER

INTO A TWO-ROOM country shack in the flood plains of a Southern Indiana creek came a new baby not long ago. The father belongs to the army of the Works Progress Administration. He owns a car of ancient vintage which looks on the verge of collapse, and in general he puts up a single-handed fight against starvation. Tin cans lie at an easy toss from the kitchen window.

Yet for the baby's comfort the father built the most scientific of baby beds. He could not recall what first gave him the idea for the bed. He had always provided a bed for each of his new babies, and had made these beds for the past ten years. From the nearby woods he gathered four upright poles from paw-paw trees, six other poles to form the sides, two for cross braces on the legs, a series of slats, and poles for a lid. The wire screening was then tacked to the sides, bottom, and lid, and the bed

was completed except for springs and mattress. It is a simple job, easily performed, and the result is most effective in use.

The yard may be black with insects, but the baby is peaceful in his screened cage where the air can circulate freely. He bounces joyfully on the springs from the seat of an old automobile, covered with a mattress of his mother's own design. When he is placed in the yard for his morning and afternoon sun baths, there is a feeling of safety in knowing that the hinged trap door is securely fastened. He is protected from cats and dogs and the wild life surrounding a country home.

HELEN WILSON KENNEDY, R.N.
Warrick County Public Health Nurse,
Boonville, Indiana

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

WITH THE STAFF

Since vacation time is here very little activity is going on in the field. However, a few short trips were made by members of the staff.

Ruth Houlton was in Boston, Mass., from June 26 to 29 attending the National Tuberculosis Association convention.

Evelyn Davis went to Laconia, N.H., on June 14 to participate in an informal discussion meeting of the New Hampshire Board Members' Organization of Public Health Nursing which met with the Public Health Nursing Section of the State Graduate Nurses' Association. From there, she went to Niagara Falls, N.Y., to attend the annual meeting of Community Chests and Councils from the sixteenth to the eighteenth. The National Conference of Social Work held its annual meeting in Buffalo, N.Y., immediately after the community chests' meeting. Miss Deming and Miss Davis were there from the eighteenth to the twenty-fourth.

On June 7 Ella McNeil went to Portland, Conn., to attend a board members' meeting under the auspices of the Board Members' Organization of Connecticut Public Health Nursing Associations to discuss the responsibilities of public health nurses in rural areas. She also spoke at the luncheon given by the Public Health Nursing Section of the Vermont State Nurses' Association in St. Albans on June 21.

HONOR ROLL

We're heading for the biggest Honor Roll year ever achieved by the N.O.P.H.N.! Over 400 agencies have been added to the list this month. This brings the total number of 100 percent services to over 700.

As soon as your staff is 100 percent enrolled in the N.O.P.H.N., let us know so that the name of your service may be added to this imposing list of 1939 Honor Roll agencies.

With your continued coöperation, 1939 will surely be the banner Honor Roll year in the history of the N.O.P.H.N. Our thanks to the nurses whose memberships have made the following services eligible.

ALABAMA

Metropolitan Life Insurance Nursing Service of Anniston, Anniston
*Shelby County Health Department, Columbiana
*Tallapoosa County Health Department, Dadeville
Greene County Health Department, Eutaw
Fayette County Health Department, Fayette
Lauderdale County Health Unit, Florence
Butler County Health Department, Greenville
*Perry County Health Unit, Marion
*Bureau of Hygiene and Nursing, State Health Department, Montgomery
*Pike County Health Unit, Troy
Bullock County Health Department, Union Springs
Randolph County Health Department, Wedowee

ARKANSAS

*Independence County Health Unit, Batesville
Fort Smith Public Schools, Fort Smith
Metropolitan Life Insurance Nursing Service, Hot Springs
Visiting Nurse Association of Greater Little Rock, Little Rock
State Board of Health—Fulton County Health Unit, Salem

*Agencies which have been on the Honor Roll list for five years or more.

Scott County Health Department, Waldron
Lawrence County Nursing Service, Walnut Ridge

ARIZONA
Miami Public Schools, Miami
Pima County Health Unit, Tucson

CALIFORNIA
*Coalinga High School District, Coalinga
Imperial County Health Department, El Centro
Humboldt County Health Department, Eureka
Metropolitan Life Insurance Nursing Service for Los Angeles City and County, Los Angeles
Ontario Health Department, Ontario
*Pittsburg Public Schools, Pittsburg
American Red Cross Visiting Nursing Service, San Jose Chapter, San Jose
Santa Barbara Visiting Nurse Association, Santa Barbara

COLORADO
Boulder County Nursing Service, Boulder
Cheyenne County Public Health Nursing Service, Cheyenne Wells
Montezuma County Public Health Nursing Service, Cortez
Delta County Nursing Service, Delta
Margery Reed Mayo Day Nursery, Denver
Durango Public Schools, Durango
*Weld County Health Department, Greeley
Gunnison County Division of Public Health, Gunnison
Routh County Public Health Service, Hayden
Grand County Department of Public Health, Hot Sulphur Springs
Indian Reservation School of Ignacio, Ignacio
*Johnstown Public School, Johnstown
Elbert County Public Health Nursing Service, Kiowa
Bent County Health Unit, Las Animas
Rio Blanco County Health Department, Meeker
Pueblo School District No. 1, Pueblo
Pueblo School District No. 20, Pueblo

CONNECTICUT
Cheshire Public Health Nursing Association, Cheshire
Metropolitan Life Insurance Nursing Service, Danielson
*District Nurse Association of Ansonia, Derby, and Shelton, Derby
Public Health Nursing Association, East Hampton
Glastonbury Visiting Nurse Association, Glastonbury
Town Nursing Service, Greenwich
Guilford Public Health Nurse Association, Guilford
Visiting Nurse Committee, Kensington
Salisbury Public Health Nursing Association, Lakeville
Madison Public Health Nursing Association, Inc., Madison
Public Health Nursing Association, Manchester
*District Nursing Association, Middletown
*American Red Cross, Naugatuck Chapter, Naugatuck
Visiting Nurse Association of New Britain, New Britain
*Visiting Nurse Association of New Canaan, New Canaan
*Newtown Visiting Nurse Association, Newtown
American Red Cross, Old Lyme Branch, Old Lyme
Orange Public Health Association, Orange
Plainville Public Health Nursing Association, Plainville
Red Cross Nursing Service, Putnam
Metropolitan Life Insurance Nursing Service, South Norwalk
Board of Education, Stamford
American Red Cross, Stafford Chapter, Stafford Springs
Stratford Red Cross Nursing Service, Stratford
Washington Visiting Nurse Association, Washington Depot
Visiting Nurse Association of the Town of Windham, Willimantic

DISTRICT OF COLUMBIA
United States Public Health Service, Washington

FLORIDA
St. Lucie County School Health Department, Fort Pierce
Board of Public Instruction of Lee County, Fort Myers
Metropolitan Life Insurance Nursing Service, Jacksonville
Columbia County Public Health Nursing Service, Lake City
Jefferson County Public Health Nursing Service, Monticello
Metropolitan Life Insurance Nursing Service, Orlando
Gulf County Public Health Nursing Service, Port St. Joe
Charlotte County Health Department, Punta Gorda
Metropolitan Life Insurance Nursing Service, St. Petersburg
Highlands County Public Health Nursing Service, Sebring
Hardee County Health Department, Wauchula

GEORGIA
Union Bag and Paper Corporation, Savannah

IDAHO
Fort Hall Nursing Service, Fort Hall
Bunker Hill and Sullivan Mining and Concentrating Company, Kellogg

ILLINOIS

*Metropolitan Life Insurance Nursing Service, Alton
Belleville Public Schools, Belleville
Metropolitan Life Insurance Nursing Service, Belleville
Carlinville Community Public Health Nursing Service, Carlinville
Goodman Manufacturing Company, Chicago
Metropolitan Life Insurance Nursing Service, Chicago
*Evanston Infant Welfare Society, Evanston
*Amity Child Welfare Society, Freeport
Freeport Board of Education, Freeport
Freeport City Health Department Nursing Service, Freeport
Stephenson County Tuberculosis Board, Freeport
City Health Department Nursing Service, Jacksonville
Western Illinois State Teachers College, Macomb
Clark County Public Health Nursing Service, Marshall
Board of Education, District 89, Maywood
Mendota Public Schools, Mendota
*Moline Public Health Nursing Service, Moline
Wabash County Nursing Service, Mt. Carmel
Pekin High School, Pekin
Public Health Nursing Association of Peoria, Peoria
Pike County Public Health Nursing Association, Pittsfield
Gallitan County Nursing Service, Ridgeway
J. L. Clark Manufacturing Company, Rockford
Rockford College Nursing Service, Rockford
*Sangamon County Tuberculosis Sanitarium Board, Springfield
Whiteside County Sanitarium Board, Sterling
Cumberland County School Health Association, Toledo
Iroquois County Public Health Nursing Association, Watseka
Lake County Tuberculosis Association, Waukegan
*Winnetka Family Welfare Society, Winnetka

INDIANA

Perry County Public Health Nursing Service, Cannelton
Elkhart Child Welfare Station, Elkhart
Evansville Public Schools, Evansville
John Hancock Mutual Life Insurance Nursing Service, Gary
Lake County Tuberculosis Association, Gary
Decatur County Nursing Service, Greensburg
*Huntington City Schools, Huntington
*Bureau of Public Health Nursing, State Board of Health, Indianapolis
Metropolitan Life Insurance Nursing Service, Kokomo
*Ball State Teachers' College Nursing Service, Muncie
*Delaware County Tuberculosis Association, Muncie
District Health Department III, Indiana State Board of Health, New Albany
*Floyd County Tuberculosis Association, New Albany
New Castle Public Health Nursing Association, New Castle
*Valparaiso City Schools, Valparaiso

IOWA

Monroe County Nursing Service, Albia
Algona Board of Education, Algona
Cedar Falls Public Schools, Cedar Falls
Appanoose County Health Department, Centerville
Charles City Board of Education, Charles City
Cherokee Board of Education, Cherokee
Wayne County Nursing Service, Corydon
*Visiting Nurse Association, Council Bluffs
*State Department of Health—Division of Public Health Nursing, Des Moines
Dubuque County Health Department, Dubuque
Dubuque School Health Department, Dubuque
Webster County Nursing Service, Fort Dodge
Indianola Board of Education, Indianola
Bureau of Dental Hygiene, Iowa State University, Iowa City
Keokuk School Nursing Service, Keokuk
Knoxville Public Schools, Knoxville
Health District No. 1, Iowa State Department of Health, LeMars
Decatur County Nursing Service, Leon
Marshalltown School, Marshalltown
Cerro Gordo County Red Cross Nursing Service, Mason City
*Public Health Nursing Association, Muscatine
Sioux County Nursing Service, Orange City
Mahaska County Nursing Service, Oskaloosa
Oskaloosa Public Schools, Oskaloosa
O'Brien County Nursing Service, Primghar
*Lyons County Nursing Service, Rock Rapids
Calhoun County Nursing Service, Rockwell City
*Visiting Nurse Association, Sioux City
Winterset Public Schools, Winterset

KANSAS

Gray County Health Department, Cimarron
Public Health Nursing Association, Coffeyville

*Agencies which have been on the Honor Roll list for five years or more.

Cherokee County for the State Health Department, Columbus
Board of Education, Emporia
Board of Education, Kansas City
American Red Cross, Wyandotte County, Kansas City
Lawrence City School, Nursing Service, Lawrence
*McPherson County Red Cross, McPherson
Newton Public Health Association, Newton
Salina City School Nursing Service, Salina
Coleman Lamp and Stove Company, Wichita
*Wichita Public Health Nursing Association, Wichita
Wichita Tuberculosis Association, Wichita

KENTUCKY

Metropolitan Life Insurance Nursing Service, Henderson
Metropolitan Life Insurance Nursing Service, Madisonville
Metropolitan Life Insurance Nursing Service, Owensboro
McCracken County Health Department, Paducah

LOUISIANA

Bossier Parish Health Unit, Benton
Jefferson Davis Parish Health Unit, Jennings
De Soto Parish Health Unit, Mansfield

MAINE

Hancock County Health Service, Ellsworth
*Gardiner Public Health Association, Gardiner
*American Red Cross, Lewiston-Auburn Chapter, Lewiston
American Red Cross, Mt. Desert Chapter, Northeast Harbor
Central Penobscot Public Health Association, Old Town
Rumford School Nursing Service, Rumford
*American Red Cross, York County Chapter, Saco

MARYLAND

Dorchester County Tuberculosis Association, Inc., Cambridge

MASSACHUSETTS

Board of Health, Arlington
*Arlington Visiting Nursing Association, Arlington
Dalton Visiting Nurse Association, Dalton
Berkshire Health District, Great Barrington
Metropolitan Life Insurance Nursing Service, Haverhill
*Metropolitan Life Insurance Nursing Service, Malden
*Milford, Hopedale, Mendon Instructive District Nursing Association, Milford
Northfield Public Health Nursing Service, Northfield
Pembroke Public Health Nursing Association, Pembroke
*Community Health Association of Richmond and West Stockbridge, Richmond
*Visiting Nurse Association, Springfield
Sturbridge Community Nursing Service, Sturbridge
Waltham District Nursing Association, Waltham

MICHIGAN

*Public Health Nursing Service of the Civic League and City of Bay City, Bay City
*Berkley-Huntington Woods School District No. 7, Berkley
*Detroit Visiting Nurse Association, Detroit
*North End Clinic, Detroit
Out Patient Nursing Service, Harper Hospital, Detroit
*Community Health Service of Grand Rapids, Grand Rapids
Metropolitan Life Insurance Nursing Service, Jackson
Mason-Manistee County Health Unit No. 8, Manistee
Midland County Department of Health, Midland
Metropolitan Life Insurance Nursing Service, Port Huron

MINNESOTA

Itasca County Nursing Service—Northern District, Bigfork
Chisholm Department of Health, Chisholm
American Red Cross, Duluth Chapter, Duluth
Metropolitan Life Insurance Nursing Service, Duluth
State Teachers College, Duluth
Itasca County Nursing Service—Southern District, Grand Rapids
Hutchinson School Nursing Service, Hutchinson
Jackson County Nursing Service, Jackson
Rochester School Nursing Service, Rochester
*St. Paul Family Nursing Service, St. Paul

MISSISSIPPI

Lincoln County Health Department, Brookhaven
Metropolitan Life Insurance Nursing Service, Laurel
Metropolitan Life Insurance Nursing Service, Meridian
Choctaw Indian Agency, Philadelphia
Oktibbeha County Health Department, Starkville

MISSOURI

Division of Public Health Nursing, State Department of Health, Jefferson
Metropolitan Life Insurance Nursing Service, Moberly
Lewis County Nursing Service, Monticello
State Board of Health, District No. 9, Owensville

Washington County Nursing Service, Potosi
Ray County Nursing Service, Richmond
Atchison County Public Health Nursing Service, Rock Port
Quaker Oats Company, St. Joseph
*Visiting Nurse Association of St. Louis, St. Louis

MONTANA
State Normal College and Public School System, Dillon
Division of Maternal and Child Health, State Board of Health, Helena

NEW HAMPSHIRE
*American Red Cross, Ossipee Chapter, Center Ossipee
New Hampshire State Cancer Commission, Concord
State Board of Education, Concord
*Groveton Public Health Nursing Association, Groveton
Union School District, Keene
*American Red Cross, Lancaster Chapter, Lancaster
Laconia Nursing Service, Laconia
*American Red Cross, Milton Branch, Milton
*Pittsfield Public Health Nursing Association, Pittsfield
*Portsmouth District Nursing Association, Portsmouth
American Red Cross, Wolfeboro Chapter, Wolfeboro

NEW JERSEY
*American Red Cross, Bridgeton Chapter, Bridgeton
Metropolitan Life Insurance Nursing Service, Burlington
*Camden County Tuberculosis Association, Camden
American Red Cross, Cape May Branch, Cape May
Metropolitan Life Insurance Nursing Service, Dover
Elizabeth Visiting Nurse Association, Elizabeth
*Matawan Public Health Association, Matawan
*Moorestown Visiting Nurse Association, Moorestown
State Teachers College, Newark
*Visiting Nurse Association of the Oranges and Maplewood, Orange
Pitman District Office, State Department of Health, Pitman
*Monmouth County Organization for Social Service, Inc., Red Bank
*Red Bank Public Health Nursing Association, Red Bank
*Salem Child Welfare and Visiting Nurse Association, Salem
Salem City Board of Education, Salem
Visiting Nurse Association, Trenton
*District Nursing Association, Westfield

NEW MEXICO
Curry County Health Department, Clovis
*DeBaca County Health Department, Fort Sumner
Harding County Health Department, Mosquero
Colfax County Health Department, Raton
*Socorro County Health Department, Socorro

NEW YORK
Akron High School, Akron
State Education Department, Albany
Metropolitan Life Insurance Nursing Service, Batavia
Metropolitan Life Insurance Nursing Service, Binghamton
*Buffalo Tuberculosis Association of Erie County, Buffalo
*American Red Cross, East Aurora Branch, East Aurora
District State Health Office, Geneva
*Public School No. 7 of Hartsdale, Hartsdale
John Hancock Visiting Nurse Service, Hempstead
Queens Metropolitan Western, Jackson Heights
*Kenmore and Tonawanda Town Health Department, Kenmore
Metropolitan Life Insurance Nursing Service, Kingston
*District Nursing Association of Lawrence, Long Island, Lawrence
State Department of Health, Lowville
Metropolitan Life Insurance Visiting Nurse Service, Mechanicville
Town of Marlboro Nursing Service, Milton
Henry Street Visiting Nurse Service, Morrisania Branch, New York
National Surety Corporation, New York
Metropolitan Life Insurance Nursing Service, Ogdensburg
Metropolitan Life Insurance Nursing Service, Patchogue
Metropolitan Life Insurance Nursing Service, Peekskill
Metropolitan Life Insurance Nursing Service, Poughkeepsie
Metropolitan Life Insurance Nursing Service, Tonawanda
Metropolitan Life Insurance Nursing Service, Watertown

NORTH CAROLINA
Metropolitan Life Insurance Visiting Nurse Service, Burlington
Metropolitan Life Insurance Nursing Service, Forest City
Metropolitan Life Insurance Nursing Service, High Point

NORTH DAKOTA
Walsh County Public Health Nursing Service, Grafton

OHIO
*Barberton Red Cross Nursing Service, Barberton

*Agencies which have been on the Honor Roll list for five years or more.

Visiting Nurse Association of Cincinnati, Cincinnati
Frank B. Willis High School, Delaware
Metropolitan Life Insurance Nursing Service, East Liverpool
*Kent Red Cross Visiting Nurse Association, Kent
Metropolitan Life Insurance Nursing Service, Marion
Metropolitan Life Insurance Nursing Service, Piqua
Metropolitan Life Insurance Nursing Service, Sandusky
Metropolitan Life Insurance Nursing Service, Zanesville

OKLAHOMA

Metropolitan Life Insurance Nursing Service, Enid
Tillman County Health Unit, Frederick
Payne County Health Unit, Stillwater

OREGON

Clatsop County Health Department, Astoria
Polk County Health Association, Dallas
Union County Health Unit, LaGrande
Malheur County Public Health Association, Ontario
Crippled Children's Division, State Public Welfare Commission, Portland
Wasco County Health Unit, The Dalles

PENNSYLVANIA

Visiting Nurse Service, Allentown
*North Penn Community Centre, Ambler
Visiting Nurse Association, Bethlehem
*Delaware County Tuberculosis Association, Chester
*American Red Cross, Latrobe Chapter, Latrobe
*Lewisburg Community Nurse Association, Lewisburg
*Mount Pleasant American Red Cross, Mount Pleasant
*Palmerton School District, Palmerton
*King's Daughters Society, Pottsville
Metropolitan Life Insurance Nursing Service of Sharon, Sharon
Uniontown Public Schools, Uniontown
*Chester Valley Red Cross Community Nurse Association, Whitford

RHODE ISLAND

Bristol School Department, Bristol
*Richmond Visiting Nurse Association, Carolina
*North Providence District Nursing and Tuberculosis Association, Centerdale
Cranston School Health Division, Cranston
*Cranston District Nursing Association, Cranston
East Providence District Nursing Association, East Providence
*John Hancock Mutual Life Insurance Nursing Service, Newport
Newport Hospital School for Nurses, Newport
North Providence District and Tuberculosis Association, North Providence
H. and B. American Machine Company, Pawtucket
*American Red Cross, Portsmouth Branch, Portsmouth
Builders Iron Foundry, Providence
City Health Department, Providence
Davol Rubber Company, Providence
Gorham Manufacturing Company, Providence
Nicholson File Company, Providence
Texas Company, Providence
*Universal Winding Company, Providence
*Sayles Finishing Plants, Inc., Saylesville
*Warren District Nursing Association, Warren
North Kingstown Visiting Nurse and Anti-Tuberculosis Association, Wickford

SOUTH CAROLINA

Metropolitan Life Insurance Nursing Service, Charleston
County Health Department, Florence
Greenville County Council for Community Development, Greenville
Metropolitan Life Insurance Nursing Service, Greenville
Calhoun County Health Department, St. Matthews

SOUTH DAKOTA

Aberdeen Public Schools, Aberdeen
Brown County Health Department, Aberdeen

TENNESSEE

Metropolitan Life Insurance Nursing Service, Cleveland
Humphreys-Houston District Health Department, Erin
Lincoln County Health Department, Fayetteville
*Williamson County Health Unit, Franklin
Lauderdale County Health Unit, Ripley

TEXAS

Taylor County Red Cross Chapter, Abilene
Chambers County Health Department, Anahuac
Brazoria County Public Health Nursing Service, Angleton
Texas Tuberculosis Association, Austin
Travis County Health Department, Austin
*Brazos County Nursing Service, Bryan
Public Health District No. 4—State Health Department, Bryan
Milam County Public Health Board, Cameron
Van Zandt County Health Department, Canton
Corpus Christi-Nueces County Health Unit, Corpus Christi
Denison Public Schools, Denison
Southern Pacific Railroad in Houston and Louisiana, Houston
District No. 3, State Department of Health, Kaufman
District No. 5, State Department of Health, Kingsville

Liberty County Health Department, Liberty
Polk County Health Department, Livingston
Midland County Health Department, Midland
Sherman Public Schools, Sherman
Sweetwater-Nolan County Health Unit, Sweetwater
Uvalde-Zavala County Unit, Uvalde
Wichita Falls City Health Department, Wichita Falls

UTAH

*Metropolitan Life Insurance Company, Salt Lake City

VERMONT

American Red Cross, Barre Chapter, Barre

VIRGINIA

Metropolitan Life Insurance Nursing Service, Alexandria
Fairfax County Health Department, Fairfax
Metropolitan Life Insurance Nursing Service, Lynchburg

WEST VIRGINIA

Metropolitan Life Insurance Nursing Service, Clarksburg
*Huntington Tuberculosis Association, Huntington
Metropolitan Life Insurance Nursing Service, Martinsburg
Wyoming County Health Department, Mullens

WISCONSIN

Appelton City Schools, Department of School Hygiene, Appelton
Chippewa County Health Department, Chippewa Falls
Iowa County, State Department of Health, Dodgeville
Walworth County Public Health Nursing Service, Elkhorn
Metropolitan Life Insurance Nursing Service, Madison
Marinette County Health Service, Marinette
*Menasha Board of Education, Menasha
Industrial First Aid Department, Employers Mutual, Milwaukee
Door County Health Department Nursing Service, Sturgeon Bay
Bayfield County Nursing Service, Washburn

WYOMING

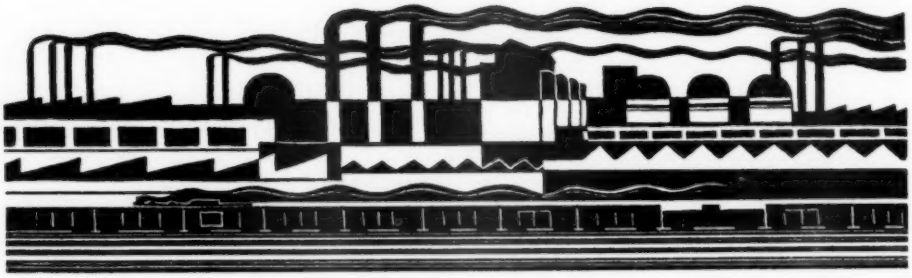
Lincoln County Health Department, Afton
Converse County Health Department, Douglas
Uinta County Health Department, Evanston
Hot Springs County Health Department, Thermopolis
Washakie County Health Department, Warland

*Agencies which have been on the Honor Roll list for five years or more.

PLAN TO ATTEND THE N.O.P.H.N. DINNER

An informal dinner is planned by the National Organization for Public Health Nursing for its membership and guests during the week of the American Public Health Association's annual meeting. It will be held in the Chatterbox restaurant of the William Penn Hotel in Pittsburgh, Pennsylvania, on Monday, October 16, at 7:00 p.m. All interested in public health nursing are invited to attend. Tickets will be $2.25 and reservations may be made in advance with the N.O.P.H.N., or at the convention, before noon, Monday, October 16.

One of the Organization's long-time friends and chairman of the N.O.P.H.N.'s Advisory Council, Dr. C.-E. A. Winslow, will preside. The address of the evening will be on a subject of vital interest today—"Preparation for Public Health Nursing—How, Where, When?"; the speaker, Katharine Tucker, director of the Department of Nursing Education, School of Education, University of Pennsylvania, and formerly general director of the N.O.P.H.N. It is expected that several foreign nurses will be present.



DESIRABLE QUALIFICATIONS OF NURSES APPOINTED TO PUBLIC HEALTH NURSING POSITIONS IN INDUSTRY

THE FUNCTIONS of the nurse in industry have been outlined by the Executive Committee of the Industrial Nursing Section of the National Organization for Public Health Nursing and were published in the October 1938 issue (page 596). This Committee and the Education Committee of the N.O.P.H.N. have formulated qualifications for nurses in industry. These qualifications were accepted by the N.O.P.H.N. Board of Directors on January 25, 1939, and by the Committee on Professional Education of the American Public Health Association on April 25, 1939.

The qualifications are suggested as aids to schools of nursing and to those arranging public health nursing curricula, in planning future training programs; and as goals for nurses who wish to prepare themselves for service in this important field.

At present the number of nurses who, through education and experience, can meet all of these qualifications is limited. The qualifications may, however, serve as a guide to employers in selecting nurses and may encourage nurses already in service to secure further preparation.

Personal qualifications

The following personal qualifications are of the utmost importance for the nurse in industry: an interest in and ability to work with all kinds of people; good physical health and emotional stability; initiative; good judgment; resourcefulness. For the nurse working alone without nursing supervision, ability to organize her service is also necessary. The supervisor of other nurses must have qualities of leadership, executive and teaching ability, vision, and imagination.

(An idea of the nurse's personal qualifications may be obtained by personal interview and by reading her record from the nursing school and from previous employers.)

Professional qualifications

I. For the nurse in an industry which provides supervision by a qualified nurse supervisor (qualifications set forth under III below):

A. High-school graduation or its educational equivalent is essential. More advanced education on a college level is desirable. Ability to use the typewriter and perform other clerical procedures is helpful to the nurse, especially in smaller industries where clerical assistance is limited.

B. Fundamental nursing education.
The following are essential:

1. Graduation from a school of nursing accredited by the state board of nurse examiners and connected with a hospital having a daily average of 100 patients, or a minimum of 50 patients with one or more affiliations affording supplementary preparation.
   a. Instruction and experience in the care of men, women, and children, including patients with communicable disease.
   b. Thorough instruction and experience in surgical nursing, including operating room and first aid.

Instruction and experience are desirable in the following:

1. Outpatient department, especially in the emergency room.
2. Psychiatric nursing.

C. State registration.

II. For the nurse in an industry working without the guidance of a nursing supervisor: This nurse should be able to plan the nursing program under the general direction of the medical officer and should have a working knowledge of the principles of teaching, social case work, community organization and resources, public health administration, industrial relations, personnel administration, industrial hazards, nutrition, communicable disease, mental hygiene, and personal hygiene, as they affect the individual and his family.

A. All of the preparation listed above under I and in addition:

1. At least one year of experience under qualified nursing supervision in a public health nursing service in which practice in the application of the above can be secured.
2. An academic year of study in public health nursing in one of the colleges or universities whose program is approved by N.O.P.H.N.
   a. Where courses in industrial hygiene and safety are available.
   b. Where courses in principles of public health nursing, mental hygiene, social work, preventive medicine, and allied subjects are made applicable to nursing in industry.
   c. Where field work includes some experience in industry.
3. Supplementary experience and instruction in operating-room and first-aid nursing, if thorough preparation was not included in the basic nursing education period.

III. For the nurse in a supervisory position: All the preparation under I and II, and in addition:

Successful experience in industrial nursing, part of which is preferably in the type of industrial work in which the nurse is to act as supervisor.

FOOD IN INDUSTRY

BUSINESSES and industries in increasing numbers are establishing nursing departments and food departments for the benefit of their employees. These services are offered to employees in banks, department stores, factories, manufacturing concerns, steel mills, and other industries, large and small. More and more the nursing and food departments are joining hands. And today many nurses in industry actively supervise the food departments to some degree—both those serving full meals and those which serve merely light, supplementary foods.

Industrial nursing has two main objectives, emergency treatment and preventive work. Preventive work means keeping employees well and on the job. Here food plays an important part. Employees must have proper food in correct amounts, substantial, well balanced, and at low cost. The nurse is not responsible for preparing either regular food or special diets, but she sees to it that the right kind of food is provided, and that it is properly prepared and tastily served so that the employee is kept in condition to perform his particular task to the best of his ability.

The number of industrial nurses assuming active supervision of the food service in industries is increasing. Of course, each industry's food requirements depend on the type of work in that industry. We are inclined to think that manual workers require heavier foods and larger quantities of food, and that office workers need only the lighter foods. But it may be surprising to learn office workers or "brain workers" require good, substantial foods, though in lesser portions. It is the overloaded stomach that results in sluggishness and sleepiness, whether the employee is engaged in manual or mental work. Well cooked food that looks and smells appetizing keeps a well stomach well and often makes a healthy stomach out of an ailing one. In industry we are

dealing primarily with well people and we want to keep them that way.

It is quite as essential for an industrial nurse to know what food the workers eat as it is to know that hazards are removed, machinery properly guarded, and sanitary working conditions provided. Days lost because of illness or hours lost because of indisposition result in lost time. Decreased efficiency in workers cannot even be computed. The nurse should know the food requirements for workers in her industry, and coöperation, at least, between the nursing and the food departments is important. In many industries the dining department is managed by persons who do not have special training—and often not *any* training or knowledge—in regard to food and nutrition, and who make no study of the food requirements of employees. The noon meal is the main meal of the day for many workers; therefore, it should be planned to furnish the largest amount of nutrition possible. The employee will usually consult the nurse for suggestions on diet in both health and illness.

The food service may vary from complete meals without cost to the employee—or perhaps only tea and coffee gratis—to food at actual cost. But in any case it is the nurse's concern to know that the food offered is well balanced and appetizing, thus making for greater efficiency, closer coöperation, and good will. In many industries employees bring their own lunches. The nurse may tactfully ascertain the kind of food the workers are eating and make helpful suggestions for the right sort of meal. No one objects to friendly help that will make him feel well, and the industrial nurse can be the medium for creating a happier atmosphere by displaying a personal interest in individual employees.

Many nurses may not feel that they have the preparation for supervision of the food in industry. However, the nurse is frequently the person in the plant or business who is best prepared to assume this responsibility, and she can supplement her knowledge by taking additional courses, by study, and by the use of nutritional consultant services offered by local and state health agencies.

The supervision of food in industry will extend the boundaries of industrial nursing, opening up a broader and more interesting field, and will make the industrial nurse of greater value to her employer, to her employees, and to herself.

MABEL C. BEELER. R.N.
Director, Medical and Welfare Department, Federal Reserve Bank, Kansas City, Missouri

Presented before the Industrial Nursing Section Round Table, Biennial Convention, Kansas City, Missouri, April 27, 1938.

MEETING OF NORTHWEST DISTRICT OF INDIANA

THE INDUSTRIAL Nurses Organization of the Northwest District of Indiana held its annual dinner on May 24 in Whiting, Indiana. The 104 guests included industrial physicians, safety directors, industrial-relations specialists, plant managers, and nurses.

A new advisory board of eight members was announced. The speaker was Wallace Bruce Amsbary of Chicago.

Inez Olson, industrial nurse in the Continental Roll and Steel Foundry, East Chicago, was elected president to succeed Victoria Stralko of the American Maize-Products Company, Roby, and Florence Carroll, of Youngstown Sheet and Tube Company, East Chicago, is the new secretary-treasurer to succeed Betty Rae of the Sinclair Refining Company, East Chicago.

EDITED BY
ELLA E. McNEIL

IMMUNITY, PRINCIPLES, AND APPLICATION IN MEDICINE AND PUBLIC HEALTH

By Hans Zinsser, M.D., John F. Edners, Ph.D., and LeRoy D. Fothergill, M.D. 801pp. The Macmillan Company, New York, N. Y., fifth edition of **Resistance to Infectious Diseases,** 1939. $6.50.

Twenty-five years have elapsed since the appearance of the first edition of this standard reference work. The fifth edition has been made much more useful for the public health nurse through an improved section dealing with the application of immunity to specific diseases.

One who undertakes to answer the questions of nurses in relation to communicable diseases knows how often there is need for a text of this sort to supplement the *Manual of Public Health Nursing*.* This volume would be an excellent choice for the staff library of each nursing agency.

The authors are to be commended for making technical information accessible in this form to persons who are not expert in laboratory research, but without the sacrifice of information essential for the specialist in immunity. The book is clear, comprehensive, and up to date.

REGINALD D. ATWATER, M.D.
Executive Secretary,
American Public Health Association,
New York, N. Y.

NURSES AT WORK

By Picture Fact Associates: Alice V. Keliher, Editor, Franz Hess, Marion LeBron, and Rudolf Modley. 57pp. Harper and Brothers, New York, 1939. 80c.

For girls graduating from high school who are thinking of taking up nursing as a profession, this book gives a general idea of the work. It presents in dialogue all the various phases of nursing from the duties of a staff nurse in a hospital to the daily routine of a public health worker. There are a great many pictures of nurses working in different places. For the more practical minded, tables of the comparative salaries of different types of jobs are given. The conclusion of the book tells a few things about the life of a student nurse and says what kind of a person you should be to become one.

Nurses at Work serves as an introduction into the field of nursing. It is written very simply and seems almost like a child's book in its "voice with a smile" manner. The authors do not go into the subject very heavily, but they certainly do justice to the good work of the whole profession.

SYLVIA STOKES
High School Student
Friends' School
Moorestown, New Jersey

YOUR COMMUNITY

Its Provision for Health, Education, Safety, Welfare

By Joanna C. Colcord. 249pp. Russell Sage Foundation, New York, 1939. 85c.

This is the successor, in convenient form, of *What Social Workers Should Know About Their Own Communities,* a pamphlet by Margaret Byington, published by the Russell Sage Foundation over twenty-five years ago.

The present volume is addressed to a larger public including citizen groups such as women's clubs and parent-teacher associations. With that end in mind it is simply and clearly written,

*National Organization for Public Health Nursing. Manual of Public Health Nursing. The Macmillan Company, New York. Revised edition to be published sometime in 1939.

and printed in large type on durable paper.

The book contains eighteen chapters dealing with the main facets of community living. Each chapter begins with a condensed, readable statement, followed by searching questions interpolated with explanatory matter. A unique departure is the use of map symbols—such as a book to represent a library, and a lantern for a social agency. Another valuable feature is the list of national agencies and sources of information. Many people do not know that they can obtain valuable material from the Bureau of the Census or the Government Printing Office.

Although *Your Community* is for the lay public, it would make an excellent study outline for nursing or social agency staffs. It is also one of the indispensable books for the executives' bookcase.

PAUL L. BENJAMIN
Buffalo, N. Y.

THE FIVE SISTERS

A Study in Child Psychology

By William E. Blatz, Ph.D. 209pp. William Morrow and Company, New York, 1938. $2.50.

These five charming little girls have enlivened universal imagination. Almost involuntarily, the world smilingly responds to news pictures and stories but it remained for Dr. Blatz's book to awaken an understanding of the full import for the future of the quintuplets' contribution to the development of child study. Nurses need only to point to their routines, to their health measures, and to their developmental and cultural opportunities to capture the interest of parents whose children will profit from a duplication of the quintuplets' well planned nurture. The fact that the quintuplets take codliver oil or play in overalls gives that blessed inspiration which is an aid to any teaching. This book provides accurate information as a basis for interpreting these sound principles in the homes which the nurse visits.

The experimental approach cannot but thrill the nurse as she learns how this magnificent phenomenon has been used to maximum advantage. After the exhaustive biological and psychological studies which he outlines, Dr. Blatz finds "no two alike" in the emerging personalities of the five sisters. Certainly this overpowering evidence supports the nurse's essential social philosophy, founded on an appreciation of differences among individuals. All of us who are groping in the field of human behavior have, perhaps, shared Dr. Blatz's hope that those who come under our guidance may come to "judge mercifully the hazardous task" we have undertaken.

KATHERINE BROWNELL OETTINGER
Scranton, Pennsylvania

MATERNITY CARE IN A RURAL COMMUNITY

Pike County, Mississippi, 1931-1936

By Maxwell E. Lapham, M.D. The Commonwealth Fund, New York, 1938. 25c.

This is a study of the maternal health program in Pike County, Mississippi, from 1931 to 1936. One of the important gaps in the nursing service was the lack of adequate nursing care at delivery. This need has since been met by a delivery nursing service established in 1938 under the health department, subsidized by The Commonwealth Fund. The suggestions for improvement of the program appended at the end of the report should be especially useful to other communities which are trying to improve their maternity services.

P. P.

HANDBOOK ON TUBERCULOSIS FOR PUBLIC HEALTH NURSES

By Violet H. Hodgson. 92 pp. National Tuberculosis Association, 50 West 50 Street, New York, 1939. 50c.

This handbook is a thoughtful presentation of known facts about tuberculosis and their implications in relation to the public health nurse's approach to any family health situation. Careful consideration is given to methods and

procedures which are applicable both to a tuberculosis program and to any other program directed toward health protection and social rehabilitation. The chapter on keeping nursing records contains challenging questions and helpful advice. The teaching responsibilities of the public health nurse are stressed throughout, and constructive suggestions are made for improving the quality of her teaching. One must study this entire handbook in order to have a full appreciation of its value.

JANE D. NICHOLSON, R.N.
Washington, D.C.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

PHARMACOLOGY, MATERIA MEDICA AND THERAPEUTICS. Charles Solomon, M.D. J. B. Lippincott Company, New York, revised 1938. 737pp. $3.

The third revision of a nursing textbook.

STATE CHILD LABOR LEGISLATION—1938. Gertrude Binder. Department of Research and Publicity, National Child Labor Committee, 1938. 9pp. Single copy free; 5c each in quantity.

A summary of the state child labor laws.

TEXTBOOK OF ANATOMY AND PHYSIOLOGY. D. C. Kimber, C. E. Gray, and C. E. Stackpole. The Macmillan Company, New York, revised 1938. 645pp. $3.

The tenth revision of a well known textbook for nurses.

TEXTBOOK OF PATHOLOGY. Armin V. St. George, M.D. The Macmillan Company, New York, revised 1938. 222pp. $1.75.

A textbook prepared for schools of nursing.

OUR UNCHANGING GOAL: THE FAMILY. Stanley P. Davies. Family Welfare Association of America, 130 East 22 Street, New York, 1938. 24pp. 20c.

Presents convincing evidence that the family has not been relieved of all of its functions as a social institution. Emphasizes the importance of the family in a democracy.

PUBLIC RELATIONS IN PUBLIC WELFARE: A DIGEST FOR INTERPRETERS. Social Work Publicity Council, 130 East 22 Street, New York, 1938. 18pp. 35c.

A presentation and explanation of current public attitudes toward relief and the need for adequate and sound relief programs.

DIVERSIONS FOR THE SICK—OCCUPATIONAL THERAPY. Life Conservation Service of the John Hancock Mutual Life Insurance Company of Boston, 1938. 32pp. Free to health and social agencies for distribution.

Practical suggestions for keeping convalescent children and adults busy.

RE-THINKING SOCIAL CASE WORK. Parts I, II, and III. Bertha C. Reynolds. *Social Work Today*, April-May-June 1938.

A series of three articles tracing "the growth of social case work in relation to the life of its times," showing how it has gradually shifted from an allegiance to the supporting group "toward a centering of its interest upon the individual client," and finally toward a more democratic administration in which clients increasingly participate. An excellent interpretation of the development of the rank-and-file movement and of changing trends in social work.

HOSPITAL CARE FOR THE NEEDY. Joint Committee of the American Hospital Association and the American Public Welfare Association. *Hospitals*, January 1939.

Reprints may be obtained from the Committee for Research in Medical Economics, 9 Rockefeller Plaza, New York, N. Y., free.

SOCIAL WORK AND LEGISLATION IN SWEDEN. The Royal Social Board. Albert Bonnier Publishing House, 561 Third Avenue, New York, revised, 1938. 352pp. $1.

ESSENTIALS OF MEDICINE. Charles P. Emerson, M.D., and Nellie Gates Brown. J. B. Lippincott Company, New York, revised, 1938. 608pp. $3.

The thirteenth revision of a textbook on medical nursing.

HEALTH EDUCATION BY ISOTYPE. Otto Neurath, Ph.D, and H. E. Kleinschmidt, M.D. American Public Health Association, 50 West 50 Street, New York, 1939. 31pp. 25c.

A discussion of the "possible uses of Isotype, which is a visual language, as a health education tool."

• A four months' program of study for public health nurses who wish advanced preparation in tuberculosis is offered by the University of Pennsylvania through the Department of Nursing Education and The Henry Phipps Institute. This program, which includes classes, conferences, clinics, and supervised field work, will be given both terms, beginning October 2 and February 2. For further information, write to Professor Katharine Tucker, Director, Department of Nursing Education, University of Pennsylvania, Philadelphia, Pa.

• The National Health Series of booklets which was written by leading health authorities in 1937 and published under the auspices of the National Health Council, has been translated into Chinese at the expense of the Chinese Nurses' Association. (See May 1937 issue, page 334, for a review of this series.)

• The officers of the Public Health Section of the Florida State Nurses' Association for 1939 are as follows: Chairman, Cynthia May Mabbette, Fort Myers; vice-chairman, Mrs. Elizabeth Perkins, Tampa; secretary, Mrs. Lydia Holtzscheiter, New Port Richey.

• The Seventy-fifth Congress passed unanimously an Act "to impose additional duties upon the United States Public Health Service in connection with the investigation and control of the venereal diseases," which was signed by the President on May 24, 1938.

The Act is intended to assist the states to strengthen their resources and personnel for combatting syphilis and gonorrhea. Funds are to be allocated to the states, to be paralleled by state appropriations.

The sum of $3,000,000 was appropriated for carrying out the purposes of the Act for the fiscal year 1939, of which $600,000 was assigned to the United States Public Health Service for research, field studies, administration, and activities of value to the country as a whole. The sum of $5,000,000 has been appropriated for the fiscal year 1940.

• Elizabeth G. Gardner has been appointed medical social worker on the staff of The National Society for the Prevention of Blindness.

• The Advisory Council of the National Association for Colored Graduate Nurses now has a membership of forty-seven people representing various educational, health, and nursing organizations throughout the country.

• The National Society for the Prevention of Blindness is planning to hold its annual conference on October 26, 27, and 28, at the Astor Hotel, New York City. Of particular interest to public health nurses will be the meetings on the subject of nursing as it relates to sight conservation, sight-saving classes, and sight conservation in industry. A complete program will be available later upon request. The headquarters of the Society is 50 West 50 Street, New York, N.Y.

• A National Rural Forum will be held under the auspices of the American Country Life Association on the Campus of the Pennsylvania State College, State College, Pa., August 30 to September 2. The keynote of the conference will be "What's ahead for rural America?" Address all inquiries to The American Country Life Association, 297 Fourth Avenue, New York, N. Y.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

SHARING IDEAS

Are other organizations wearing paper masks? We thought we were smart in hitting on the idea but perhaps we are not the first ones. We use half a paper napkin tied at both ends with cord, and the nurses have found them satisfactory. They can be used and burned.

Are there many—or any—public health nursing organizations that charge tuition to undergraduate students? If so what are the charges, and who pays them—the hospital or individual student?

PUBLIC HEALTH NURSING is certainly a great help and answers many questions. Several times lately I have stressed some point in my classes and conferences and out comes the magazine with some good article on the same subject. You have no idea how that bolsters up one's morale.

SOPHIE FEVOLD
Visiting Nurse Association,
Dayton, Ohio

EDITOR'S NOTE: In a survey made of the methods of reimbursement of public health nursing agencies for student affiliation, less than one fourth had a plan for reimbursement for undergraduate student affiliation. The amount of reimbursement varied from $2.50 to $12.50 per student month. In most instances these were not based on a complete cost computation. In the majority of cases the amount of reimbursement was paid directly to the public health nursing agency by the school of nursing and was used by the agency for improving the educational program offered to the students. A method for "Computing the Cost of Student Affiliation" was published in the December issue, page 710.

INDUSTRIAL HEALTH SECTION

May I take occasion to say "thank you" for your addition of an industrial section to PUBLIC HEALTH NURSING.

I am a student nurse in my senior year and since entering I have attempted to discover many facts about industrial nursing. This seems almost an impossible task. Having written many letters of inquiry I am still at a loss for the information I have been seeking. Your newly established section has once again roused my hopes.

Would you be able to tell me what additional training is necessary after graduating from an accredited three-year hospital course, and where such training is available?

My attitude I am sure is that of many young nurses of the present day in that we are groping around in the dark about this very interesting type of public health work.

MARGOT MCFARLAND
Meriden, Connecticut

MORE REGARDING FEES

I was interested in the article and the two letters on nursing fees in the June issue of the magazine. Here are a few additional suggestions:

1. Make the presentation of the fee as easy as possible by mechanical aids such as the provision of nurses' cards containing the fee rates, to be left in the homes, and receipts to be given the patients.

2. If a nurse is reporting a great many "free" cases, have a conference with her to discuss the basis for determining ability to pay and offer to help her make an analysis of her free cases.

3. Ask social case workers or nutrition workers in local agencies for information regarding minimum budgets in the community, to be used as a basis for determining the ability of patients to pay nursing fees. This type of help is particularly useful to the nurse in a small agency where supervisory help is not available.

4. In agencies having a mental hygiene consultant ask her to help work out some principles for approaches to the family in regard to fees.

A READER

Heading For Success

YOU too can step ahead—with the support of your National Organization which is working for your individual progress and for the progress of public health nursing as a movement.

Through your membership in the N.O.P.H.N. you can rely on the support of the combined knowledge and strength of many other workers.

You will not be alone, solving daily problems by trial and error, but can get reliable assistance from people who are continuously working to give you the best service possible and to help you on to *success!*

The N.O.P.H.N. needs your support to further the interests of public health nursing and the interests and progress of each individual member.

JOIN TODAY!

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING
50 West Fiftieth Street, New York, N. Y.

☐ I wish to apply for membership.

☐ I wish to renew my membership.

Name .....

Street .....

City and State .....

Dues for year ending December 31, 1939, $3.